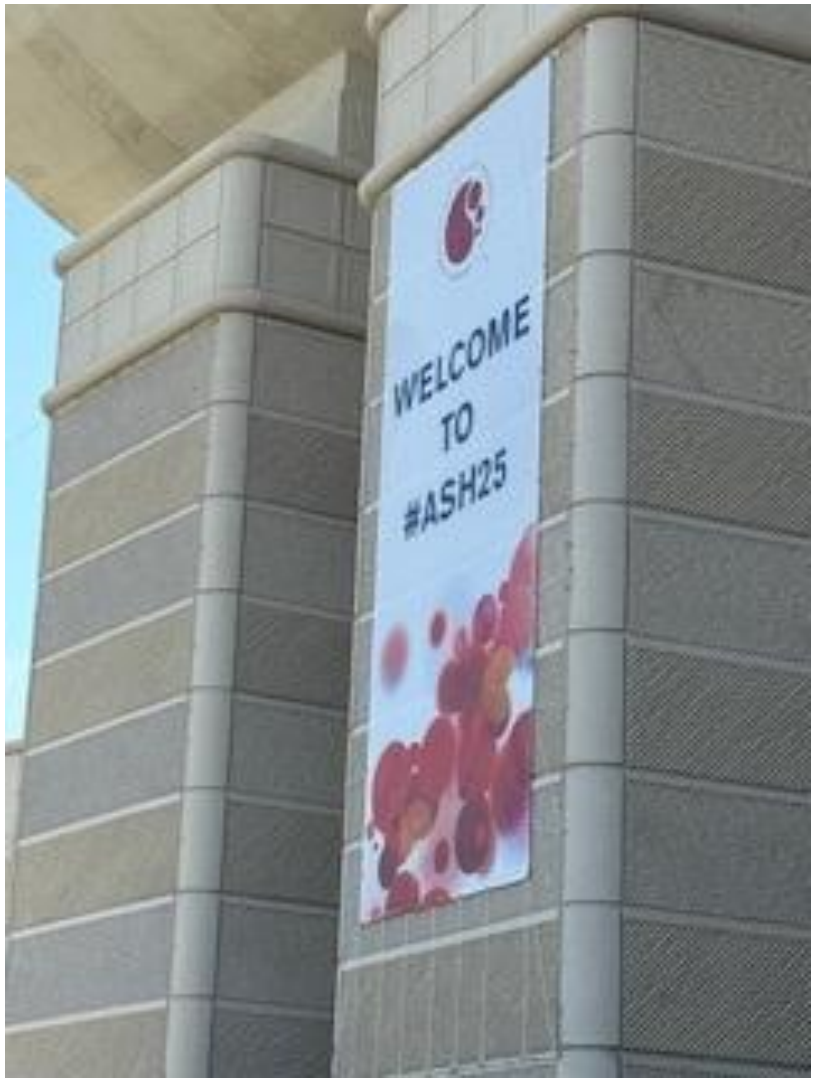
ASH 2025 Updates for Support Groups

67th Annual Meeting & Exposition
Orlando, FL
December 6-9, 2025



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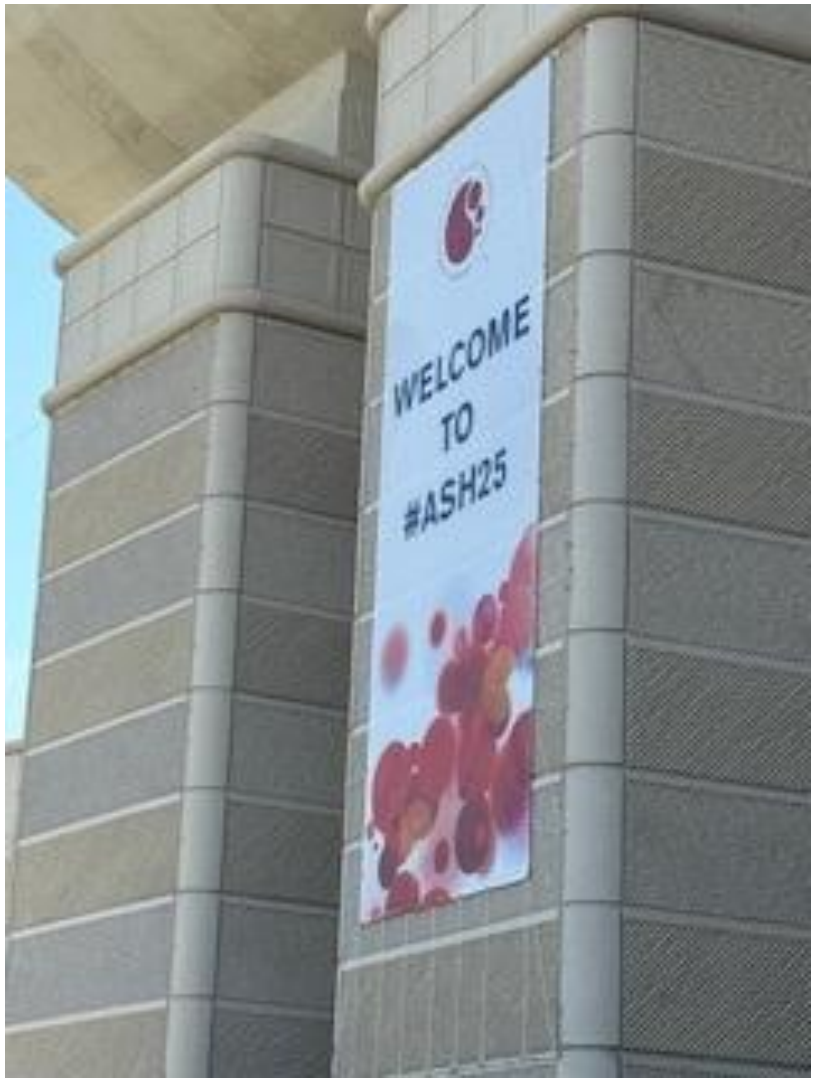
- **What is ASH?**
- **Important Terminology**
- **How does the IMF get involved?**
- **Important ASH updates**
  - Frontline Therapy
  - Early Relapse
  - Late Relapse

What is ASH?



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ASH: American Society of Hematology

ASH is the largest professional society serving both clinicians and scientists around the world who are working to conquer blood diseases.

Approximately 27,500 in person attendees and another 3,500 virtual!

Record number of abstracts submitted:

Over 9,000 (1000+ more than last year!)

Over 1,500 related to Myeloma!

including over 100 oral abstracts and 2 late breaking abstracts

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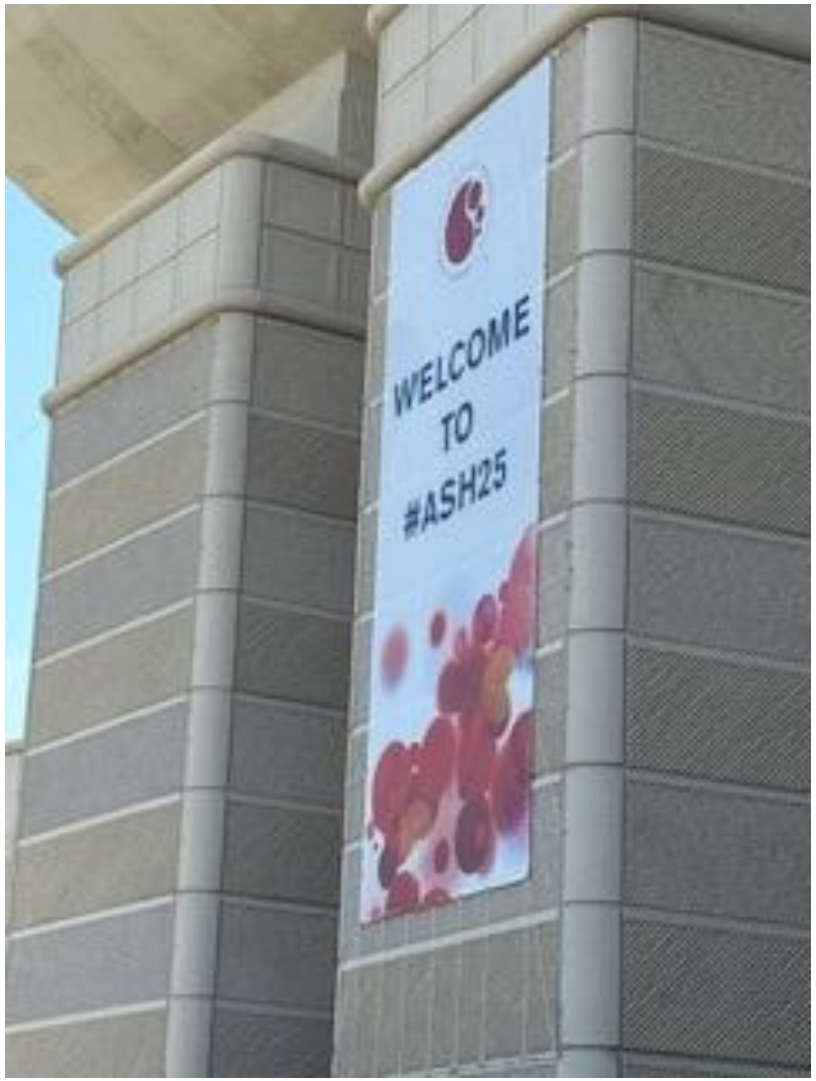
Important Terminology



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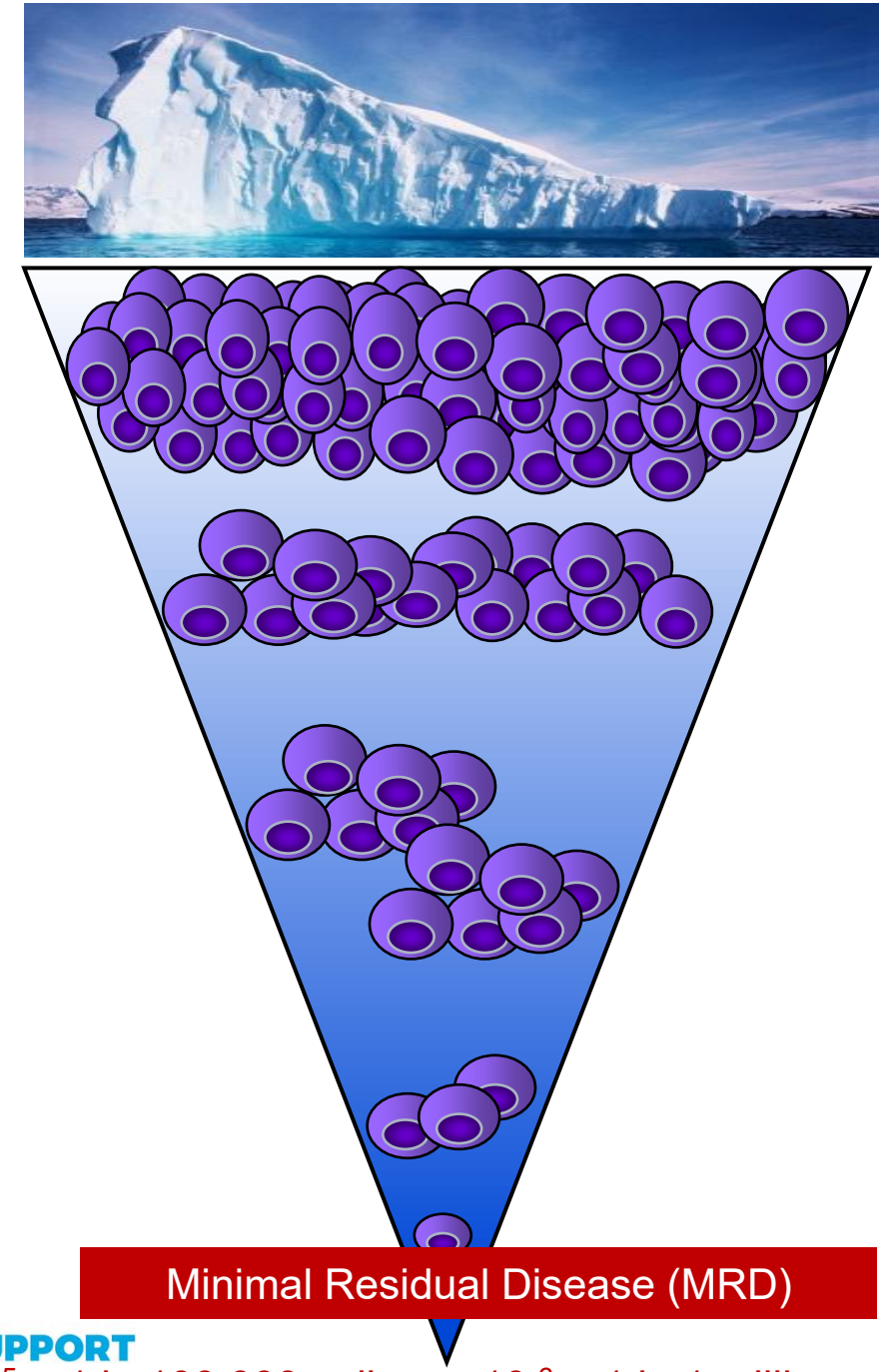
Progressive Disease (PD)
Increase of at least 10% plasma cells in marrow or 25% in serum

Stable Disease (SD)
Response doesn't meet CR, VGPR, PR, or PD



Minimal Residual Disease (MRD)

Symptomatic Myeloma

At diagnosis

Partial response (PR)
At least a 50% reduction in M protein

Very good partial response (VGPR)
At least a 90% reduction in M protein

Near Complete Response (nCR)
At least a 95% reduction in M protein

Complete response (CR)
No M-protein found in serum; less than 5% in marrow

Stringent Complete Response (sCR)
No M-Protein found in serum or marrow

[Link to Glossary of Myeloma Terminology]

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10^{-5} = 1 in 100,000 cells 10^{-6} = 1 in 1 million cells

Clinical Trials (in simple terms)

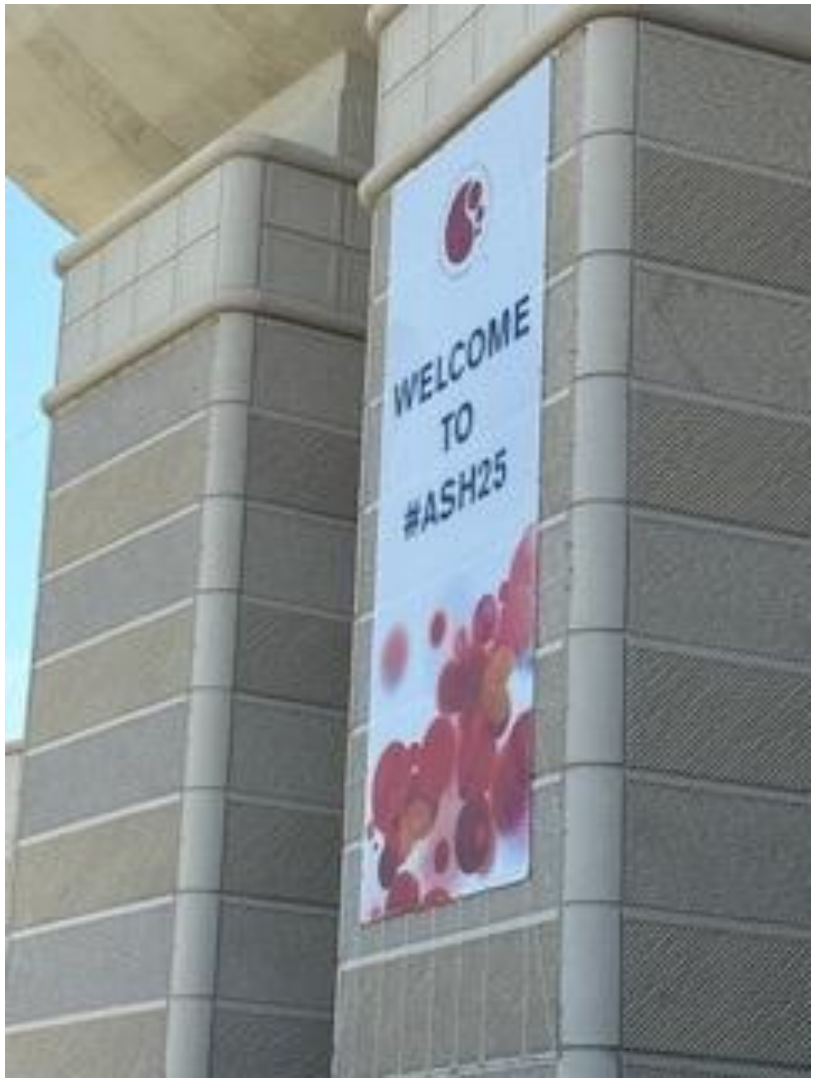
Phase 1: (Average number of participants: 15-20)
GOAL-To determine the appropriate dose, administration method, and how the agent affects the human body
First step in transforming lab research to clinical care

Phase 2: (Average number of participants: >100)
GOAL-To determine whether an agent has activity against a specific cancer type
Using the dose determined to be safe in Phase 1 trials, evaluate effectiveness & safety data

Phase 3: (Average number of participants: Hundreds to thousands)
GOAL-To determine whether a treatment is effective compared to current standard
Usually randomized to control group (no placebo-standard of care) vs investigational arm

Phase 4: Post FDA approval, various goals
Real World Data

How does the IMF Get Involved?



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IMF Myeloma Voices at ASH 2025

Patients, Care Partners,
Nurses,
Support Group Leaders…
Our Voices Matter!

Follow the Myeloma Voices at ASH team on social media and read blogs about their experiences and impressions from attending ASH

[Myeloma Voices at ASH Webpage]

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Myeloma Voices at ASH Facebook Live with Dr. Joe

IMF Chief Medical Officer Dr. Joseph Mikhael and our Myeloma Voices at ASH team went live on Facebook on the evening of Monday, December 8, to discuss the key myeloma research takeaways from the 2025 American Society of Hematology Meeting.

Replay

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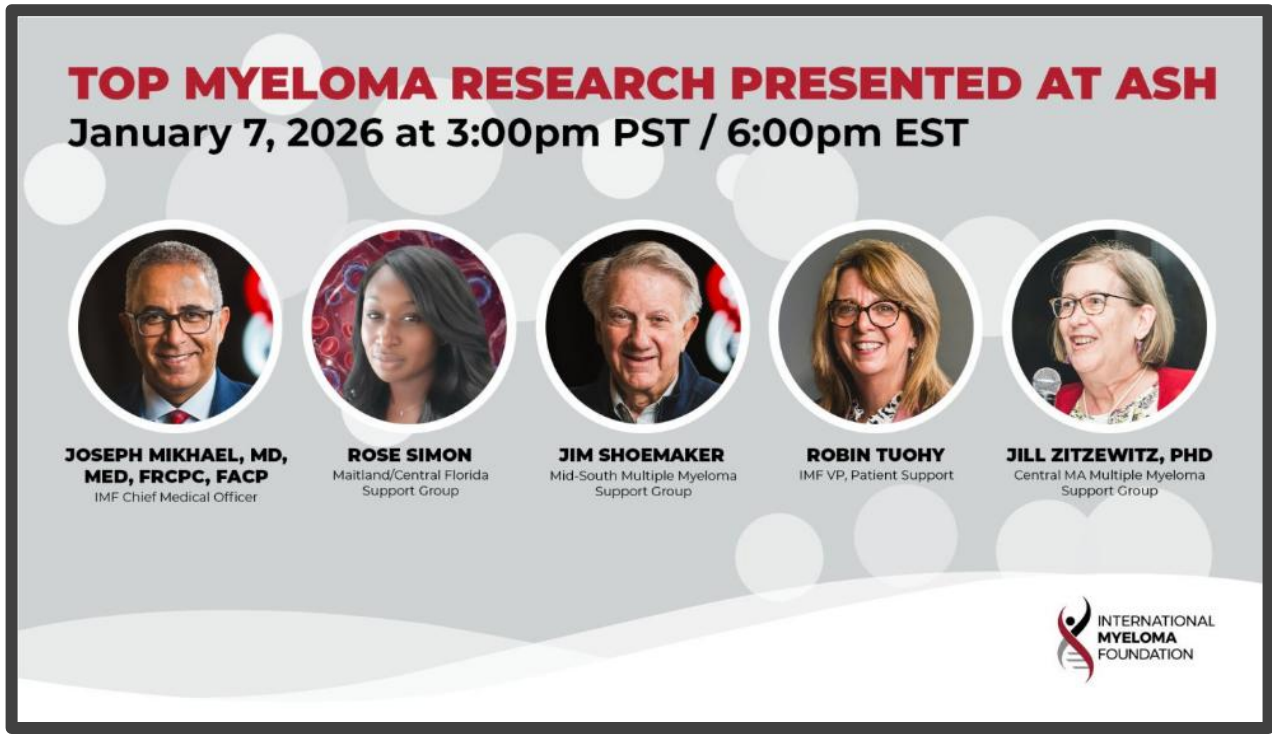
ASH 2025: IMF WEBINARS



The Myeloma Expert Perspective

Replay

The Patient Perspective

Replay

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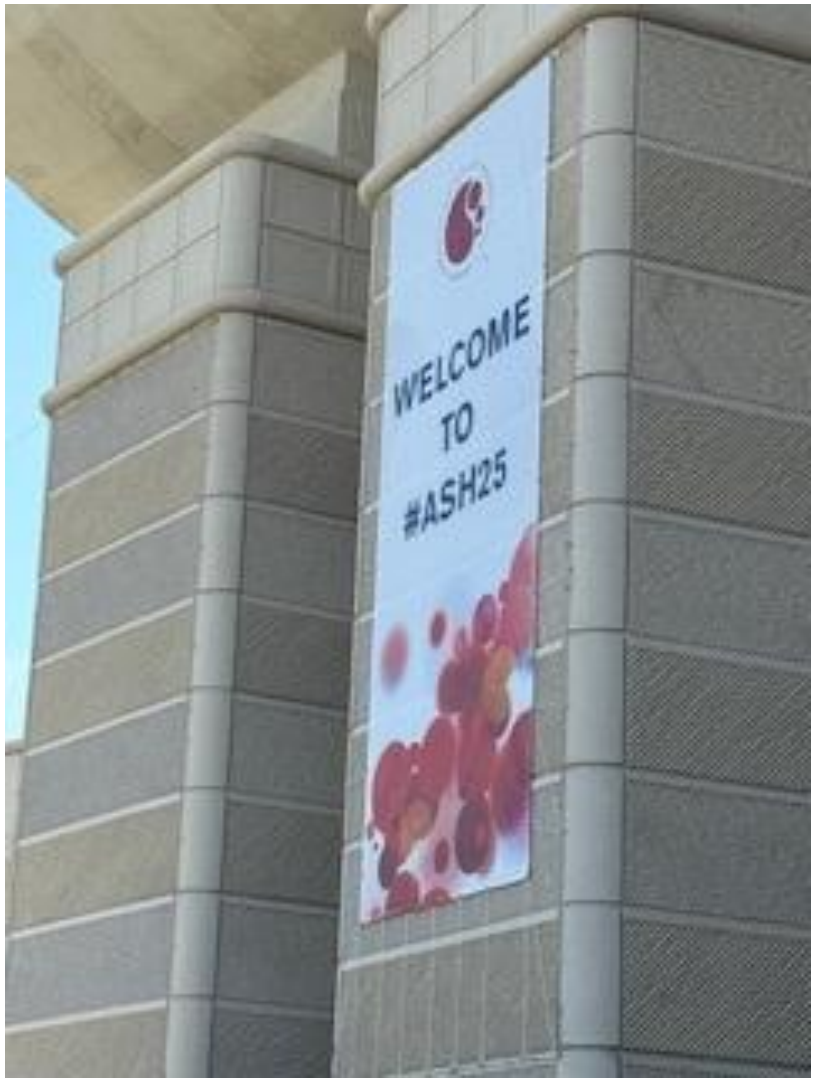
IMF's Scientific Advisory Board

INTERNATIONAL MYELOMA FOUNDATION

MYELOMA SUPPORT GROUP

Key ASH Research Updates



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ASH Updates – Three Main Important Topics

Frontline Therapy

Early Relapse
(1-3 Prior Lines)

Late Relapse
(4+ Prior Lines)

Frontline Therapy

1. Smoldering MM – AQUILA (#372)
2. BENEFIT Trial – Isa-VRD (#368)
3. Teclistamab-Daratumumab (#367)
4. Dual target fastcar frontline (#258)
5. Linvoseltamab post induction (#248)

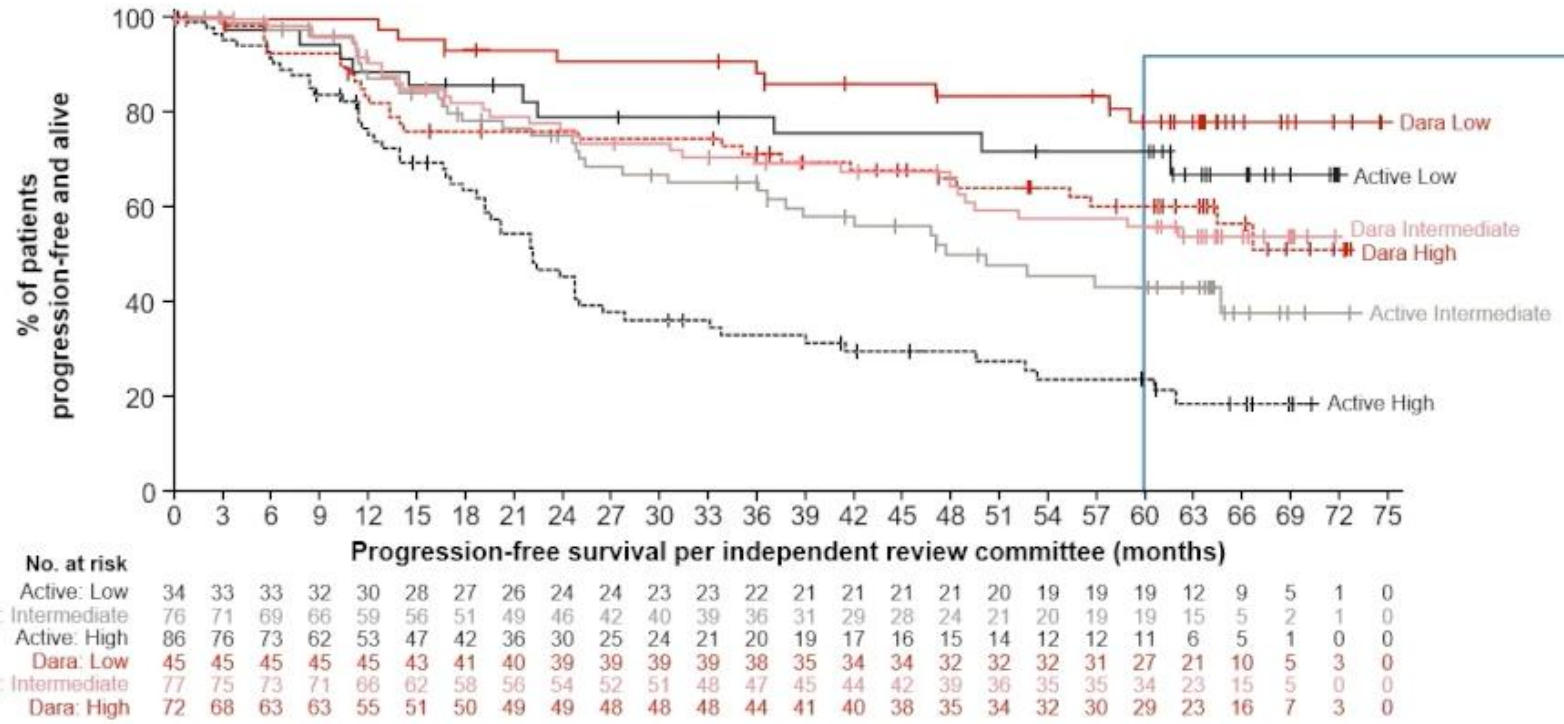
Daratumumab Monotherapy Versus Active Monitoring in Patients With High-Risk Smoldering Multiple Myeloma: AQUILA Outcomes Based on Mayo 2018/IMWG 2020 Risk Stratification, IMWG Scoring, and Age

Peter M Voorhees,[1] Meletios A Dimopoulos,[2] Yael C Cohen,[3] Fredrik Schjesvold,[4] Vania Hungria,[5] Irwindeep Sandhu,[6] Jindriska Lindsay,[7] Ross I Baker,[8] Kenshi Suzuki,[9] Hiroshi Kosugi,[10] Mark-David Levin,[11] Meral Beksac,[12] Keith Stockerl-Goldstein,[13] Hila Magen,[14] Albert Oriol,[15] Gabor Mikala,[16] Gonzalo Garate,[17] Koen Theunissen,[18] Ivan Spicka,[19] Anne K Mylin,[20] Simon Hallam,[21] Sara Bringhen,[22] Katarina Uttervall,[23] Bartosz Pula,[24] Abdullah M Khan,[25] Eva Medvedova,[26] Jing Christine Ye,[27] Andrew J Cowan,[28] Philippe Moreau,[29] María-Victoria Mateos,[30] Hartmut Goldschmidt,[31] Diego Vieyra,[32] Ashta Raval,[33] Linlin Sha,[34] Liang Li,[34] Els Rousseau,[35] Robyn M Dennis,[36] Robin L Carson,[32] S Vincent Rajkumar[37]

[1]Atrium Health/Levine Cancer Institute, Wake Forest University School of Medicine, Charlotte, NC, USA; [2]School of Medicine, National and Kapodistrian University of Athens, Athens, Greece; Korea University, Seoul, South Korea; [3]Tel-Aviv Sourasky (Ichilov) Medical Center, Tel Aviv Israel; Gray Faculty of Medical & Health Sciences, Tel Aviv University, Tel Aviv, Israel; [4]Oslo Myeloma Center, Oslo University Hospital, Oslo, Norway, and KG Jebsen Center for B Cell Malignancies, University of Oslo, Oslo, Norway; [5]Clinica Médica São Germano, São Paulo, Brazil; [6]Cross Cancer Institute, Edmonton, AB, Canada; [7]East Kent Hospitals University NHS Foundation Trust, Kent and Canterbury Hospital, Canterbury, UK; [8]Perth Blood Institute, Murdoch University, Perth, Australia; [9]Japanese Red Cross Medical Center, Tokyo, Japan; [10]Ogaki Municipal Hospital, Ogaki City, Japan; [11]Albert Schweitzer Hospital, Dordrecht, the Netherlands; [12]Ankara University, Ankara, Turkey; [13]Washington University School of Medicine, St. Louis, MO, USA; [14]Chaim Sheba Medical Center, Ramat-Gan, Israel; Sackler Faculty of Medical and Health Sciences, Tel Aviv University, Israel; [15]Institut Català d'Oncologia and Institut Josep Carreras, Hospital Germans Trias i Pujol, Badalona, Barcelona, Spain; [16]South Pest Central Hospital, National Institute for Hematology and Infectious Diseases, Budapest, Hungary; [17]Hospital Alemán, Buenos Aires, Argentina; [18]Jessa Hospital, Hasselt, Belgium; [19]Charles University and General Hospital, Prague, Czech Republic; [20]Rigshospitalet, University of Copenhagen, Copenhagen; [21]St Bartholomew's Hospital, London, UK, and Queen Mary University of London, London, UK; [22]SSD Clinical Trials in Oncol-ematologia e Mieloma Multiplo, AOU Città della Salute e della Scienza di Torino, Turin, Italy; [23]Medical Unit Hematology, Karolinska University Hospital, Stockholm, Sweden; [24]Institute of Hematology and Transfusion Medicine, Warsaw, Poland; [25]The Ohio State University Comprehensive Cancer Center, Columbus, OH, USA; [26]Knight Cancer Institute, Oregon Health and Science University, Portland, OR, USA; [27]MD Anderson Cancer Center, University of Texas, Houston, TX, USA; [28]Fred Hutchinson Cancer Center, University of Washington, Seattle, WA, USA; [29]University Hospital Hôtel-Dieu, Nantes, France; [30]University Hospital of Salamanca, IBSAL, and Cancer Research Center, IBMCC, Salamanca, Spain; [31]Internal Medicine V, Hematology, Oncology and Rheumatology, GMMG Study Group, Heidelberg University Hospital and National Center for Tumor Diseases, Heidelberg, Germany; [32]Johnson & Johnson, Spring House, PA, USA; [33]Johnson & Johnson, Raritan, NJ, USA; [34]Johnson & Johnson, Shanghai, China; [35]Johnson & Johnson, Beerse, Belgium; [36]Johnson & Johnson, Wayne, PA, USA; [37]Division of Hematology, Mayo Clinic, Rochester, MN, USA

Presented by P Voorhees at the 67th American Society of Hematology (ASH) Annual Meeting; December 6–9, 2025; Orlando, FL, USA

AQUILA: IMWG 2020 Subgroups: PFS



No. at risk																									
Active: Low	34	33	33	32	30	28	27	26	24	24	23	23	22	21	21	21	21	20	19	19	19	12	9	5	1	0
Active: Intermediate	76	71	69	66	59	56	51	49	46	42	40	39	36	31	29	28	24	21	20	19	19	15	5	2	1	0
Active: High	86	76	73	62	53	47	42	36	30	25	24	21	20	19	17	16	15	14	12	12	11	6	5	1	0	0
Dara: Low	45	45	45	45	45	43	41	40	39	39	39	39	38	35	34	34	32	32	32	31	27	21	10	5	3	0
Dara: Intermediate	77	75	73	71	66	62	58	56	54	52	51	48	47	45	44	42	39	36	35	35	34	23	15	5	0	0
Dara: High	72	68	63	63	55	51	50	49	49	48	48	48	44	41	40	38	35	34	32	30	29	23	16	7	3	0

60-month PFS rates, %:

IMWG 2020 Risk group	Daratumumab	Active monitoring
Low	78.2	71.6
Intermediate	56.2	42.9
High	60.4	23.6

PFS active monitoring vs daratumumab monotherapy, high-risk group:
62.8% vs 37.5% events
HR 0.36 (95% CI: 0.23, 0.58)

Daratumumab monotherapy showed a PFS benefit vs active monitoring across IMWG 2020 risk subgroups, with the largest benefit observed in the high-risk subgroup

IMWG 2020 (aka Mayo 2018 or 20-2-20) risk stratification: BMPC >20%, monoclonal spike >2 g/dL, serum l/U FLC ratio >20.
0 factors=low risk; 1 factor=intermediate risk; ≥2 factors=high risk

BMPC, bone marrow plasma cells; FLC, free light chain; IMWG, International Myeloma Working Group; PFS, progression-free survival; SC, subcutaneous; SMM smoldering multiple myeloma.

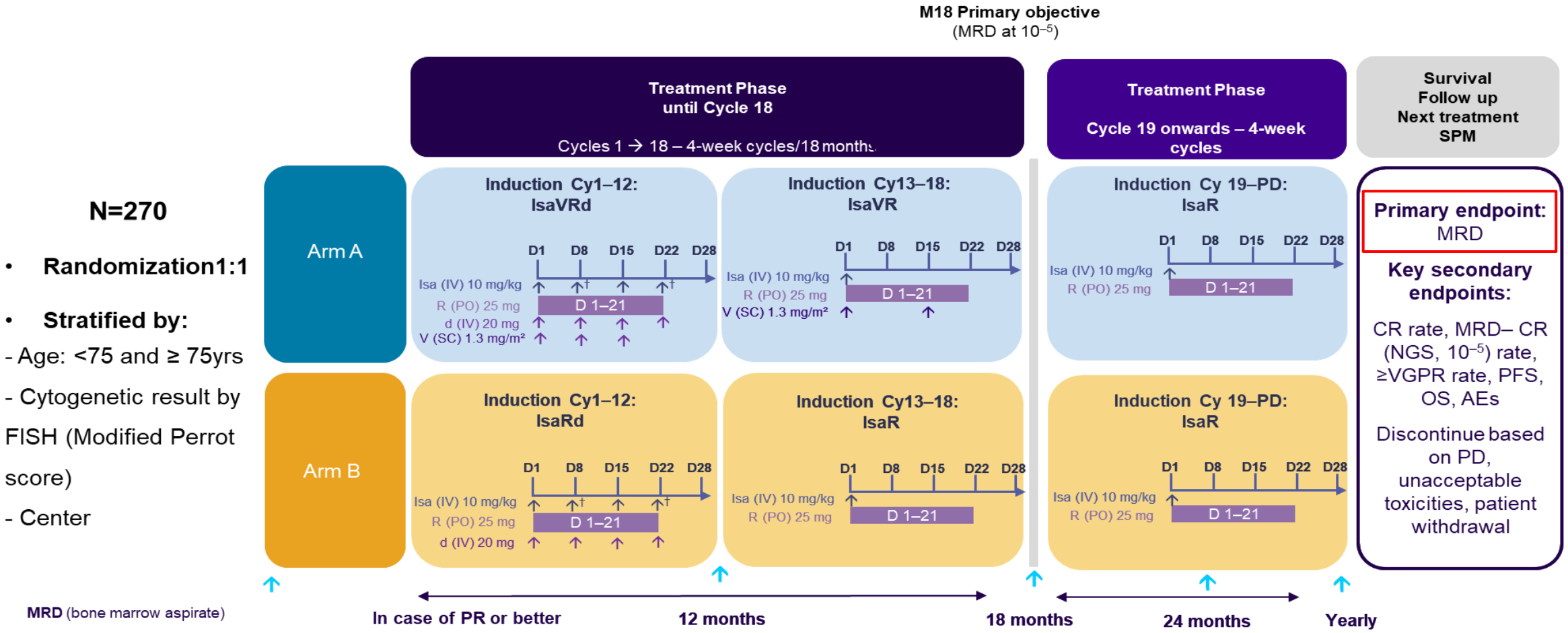
Presented by P Voorhees at the 67th American Society of Hematology (ASH) Annual Meeting; December 6–9, 2025; Orlando, FL, USA

Sustained minimal residual disease in BENEFIT phase 3 randomized study of Isatuximab plus Lenalidomide and Dexamethasone with Bortezomib (Isa-VRd) versus IsaRd in newly diagnosed transplant ineligible Multiple Myeloma (IFM 2020-05)

Arthur Bobin, Jerome Lambert, Jill Corre, Salomon Manier, Aurore Perrot, Lionel Karlin, Murielle Roussel, Noemie Bigot, Omar Benbrahim, Olivier Allangba, Philippe Rey, Véronique Dorvaux, Marguerite Vignon, Virginie Roland, Réda Garidi, Jean-Noel Bastie, Marie-Lorraine Chretien, Sophie Godet, Lydia Montes, Brieuc Chere, Souhila Ikhlef, Anne Vekhoff, Thomas Chalopin, Borhane Slama, Kamel Laribi, Claire Dingremont, Christophe Roul, Valentine Richez-Olivier, Clara Mariette, Sophie Rigaudeau, Claire Calmettes, Mamoun Dib, Mourad Tiab, Laure Vincent, Jacques Delaunay, jean-Pierre Marolleau, Pascal Godmer, Sabrina Maheo, Anais, Schavgoulidze, Laurent Frenzel, Ronan Le Calloch, Emilie Chalayer, Helene Gardeney, Margaret Macro, Bruno Royer, Stephanie Harel, Olivier Decaux, Bertrand Arnulf, Karim Belhadj, Cyrille Touzeau, Mohamad Mohty, Aurelie Gontier, Philippe Moreau, Thierry Facon, Cyrille Hulin, Xavier Leleu

Presented at the 67th Annual American Society of Hematology Meeting, Orlando, USA, December 6-9, 2025

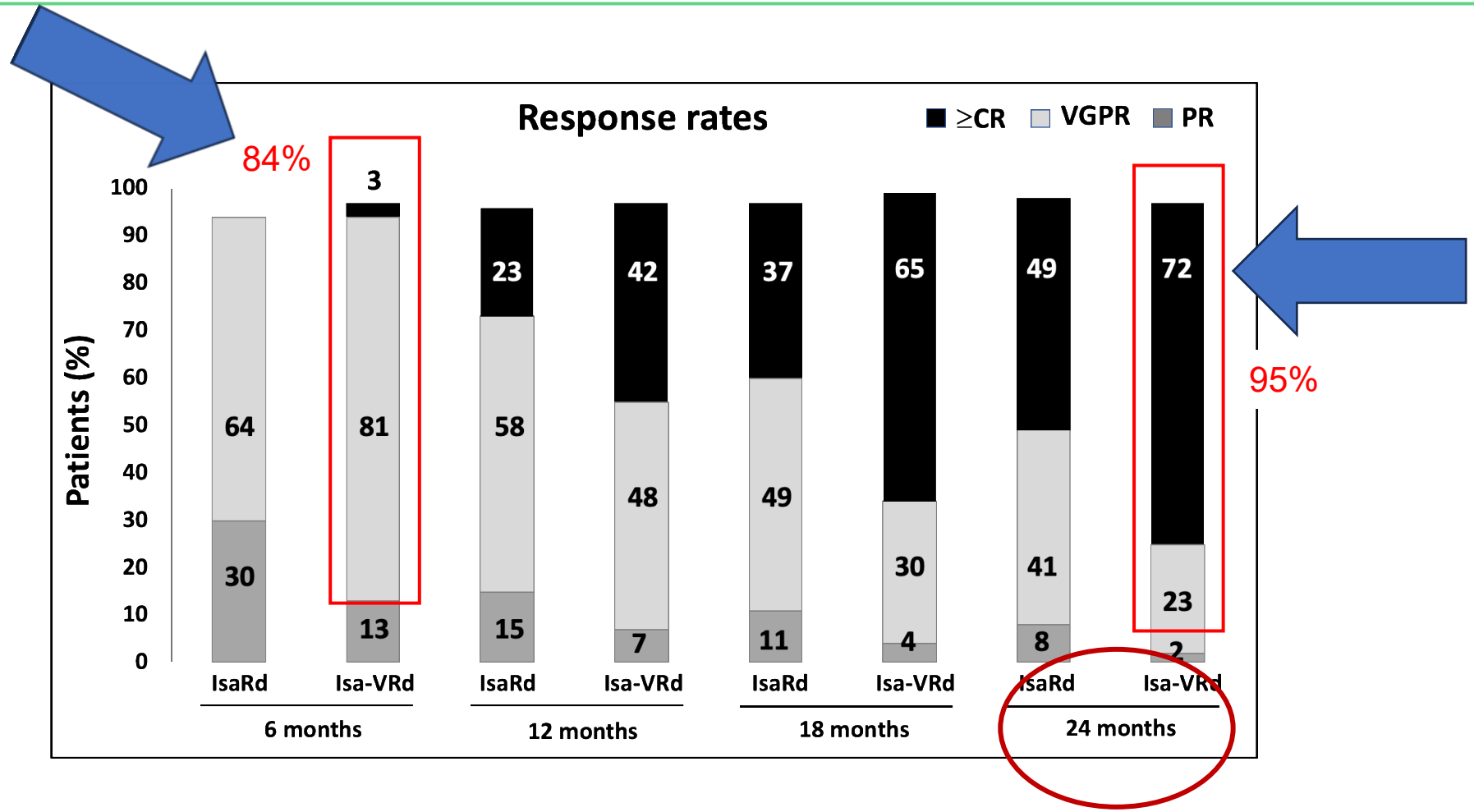
Study design: Isa-VRd vs Isa-Rd in TI NDMM



†Cycle 1 only. CR, complete response; Cy, cycle; d, dexamethasone; D, day; Isa, isatuximab; M, month; MRD, minimal residual disease; NDMM, newly diagnosed multiple myeloma; NGS, next generation sequencing; OS, overall survival; PD, progressive disease; PFS, progression-free survival; PR, partial response; R, lenalidomide; SPM, second primary malignancy; Ti, transplant-ineligible; V, bortezomib; VGPR, very good partial response.

Leleu, X. *et al. Nat. Med.* **30**, 2235–2241 (2024).

Depth of response at 12, 18 and 24 months - ITT Population

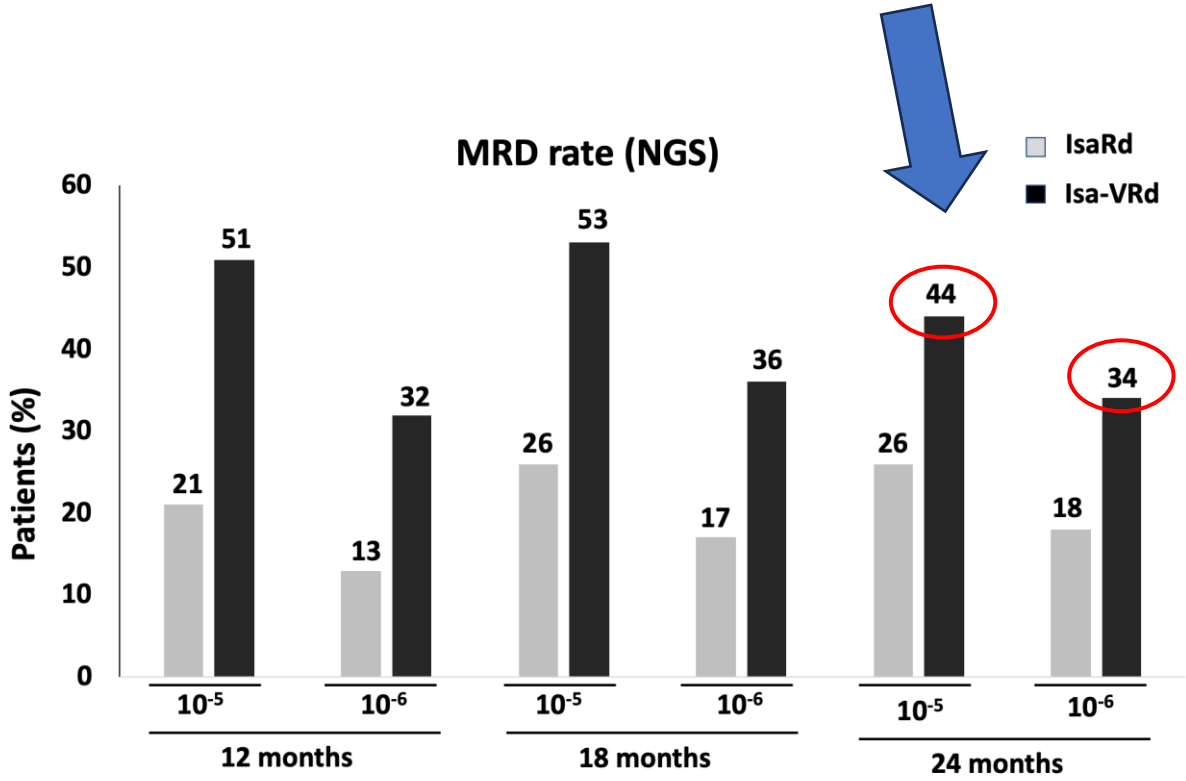


Isa-VRd resulted in deep response rates, including ≥CR rate, at all timepoints

CI, confidence interval; CR, complete response; GCS, international genomic staging consensus; IMWG, International myeloma working group; ITT, intention-to-treat; MRD, minimal residual disease; NGS, next generation sequencing; no., number; OR, odds ratio; ORR, overall response rate; %, percentages; PR, partial response; VGPR, very good partial response.

MRD– rate at 12, 18 and 24 months – ITT population

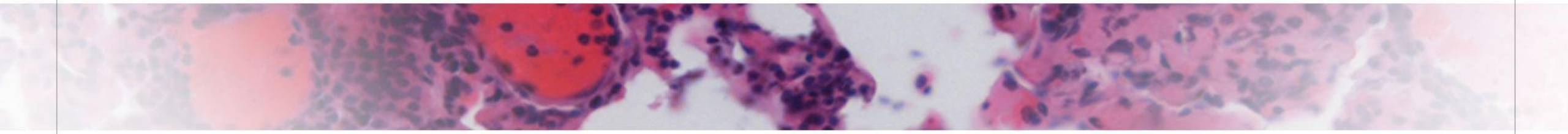
	IsaRd (n=135)	Isa-VRd (n=135)	OR (95%CI), p-value
At 12 months			
MRD- 10^{-5}	29 (21) [15-29]	69 (51) [42-60]	3.88 (2.27 - 6.62), <0.0001^{+}
MRD- 10^{-6}	18 (13) [8-20]	43 (32) [24-40]	2.97 (1.6 - 5.5), 0.0005^{+}
At 18 months			
MRD- 10^{-5}	35 (26) [19-34]	71 (53) [44-61]	3.16 (1.89 - 5.28), <0.0001
MRD- 10^{-6}	23 (17) [11-24]	49 (36) [28-45]	2.74 (1.54 - 4.87), 0.0006^{+}
At 24 months			
MRD- 10^{-5}	35 (26) [19-34]	59 (44) [35-53]	2.26 (1.34 - 3.79), 0.002
MRD- 10^{-6}	24 (18) [12-25]	46 (34) [26-43]	2.39 (1.35 - 4.22), 0.003



Isa-VRd resulted in a significant improvement in the MRD at 24 months at 10^{-5} and 10^{-6} in the ITT population

MRD was performed on bone marrow aspiration in patients at least in ≥PR for the primary endpoint timepoint at 18 months. In ITT analysis, the patients with primary refractory disease, stable disease and minor response, along with patients failing MRD analysis, will be considered as patients with MRD positive at 10^{-5}. The MRD test was centrally and primarily determined by next generation sequencing (NGS) with a 10^{-5} sensitivity (Pr Avet Loiseau / Pr Corre, Toulouse Oncopole, France). In case of failure to perform MRD by NGS, MRD assessment was then performed centrally using multiparametric flow cytometry (MFC) with a 10^{-5} sensitivity (Dr Francois Vergez, Toulouse Oncopole, France) [21]. Next Generation Sequencing was performed using the Food and Drug Administration-approved Clonoseq 2.0™ assay in accordance with IMWG guidelines on assessment of MRD [20]. Limit of Detection (LOD) and MRD status were determined using Adaptive's validated algorithms for the clonoSEQ V2.0 assay. MRD was assessed on the basis of IMWG recommendations.
MRD results are compared between treatment groups and treatment effect is assessed by odds ratio and 95% confidence interval using a mixed logistic regression with treatment as the explanatory variable and adjusting for randomization stratification factors. Interaction test are maximum likelihood test of an interaction term included in a logistic regression model. Square represents the estimated OR, and horizontal bars correspond to 95% CI. All statistical test used are two-sided with no correction for multiple comparisons.
HRMM definition according to the GCS. Fourteen patients (Isa-VRd n=6 and IsaRd n=7) failed to have cytogenetic analyzed and were classified as non-HR in the ITT analysis.
Sustained negative MRD ≥12 months (12-24 months). MRD negative at 12, 18 and 24 months. Sustained negative MRD 18-24 months. MRD negative at 18 and 24 months.
CI, confidence interval; FISH, fluorescence *in situ* hybridization; GCS, international genomic staging consensus; HR, high-risk; IMS, international myeloma society; ITT, intention-to-treat; MRD, minimal residual disease; NGS, next generation sequencing; no., number; %, percentages; s., sustained.

American Society of Hematology
Helping hematologists conquer blood diseases worldwide



A phase 2 study of teclistamab in combination with daratumumab in elderly patients with newly diagnosed multiple myeloma: the IFM2021-01 TecLille trial, cohort A

S. Manier, J. Lambert, M. Macro, T. Chalopin, M. Dib, A. Rumpler, J. Gay, J.-N. Bastie, C. Jacquet, C. Sonntag, L. Vincent, A. Perrot, C. Mariette, L. Montes, S. Rigaudeau, N. Bigot, M. Doyle, D. Santra, P. Smirnov, C. Albrecht, C. Touzeau, J. Corre, P. Moreau, H. Avet-Loiseau, C. Hulin, X. Leleu, T. Facon

Abstract #367

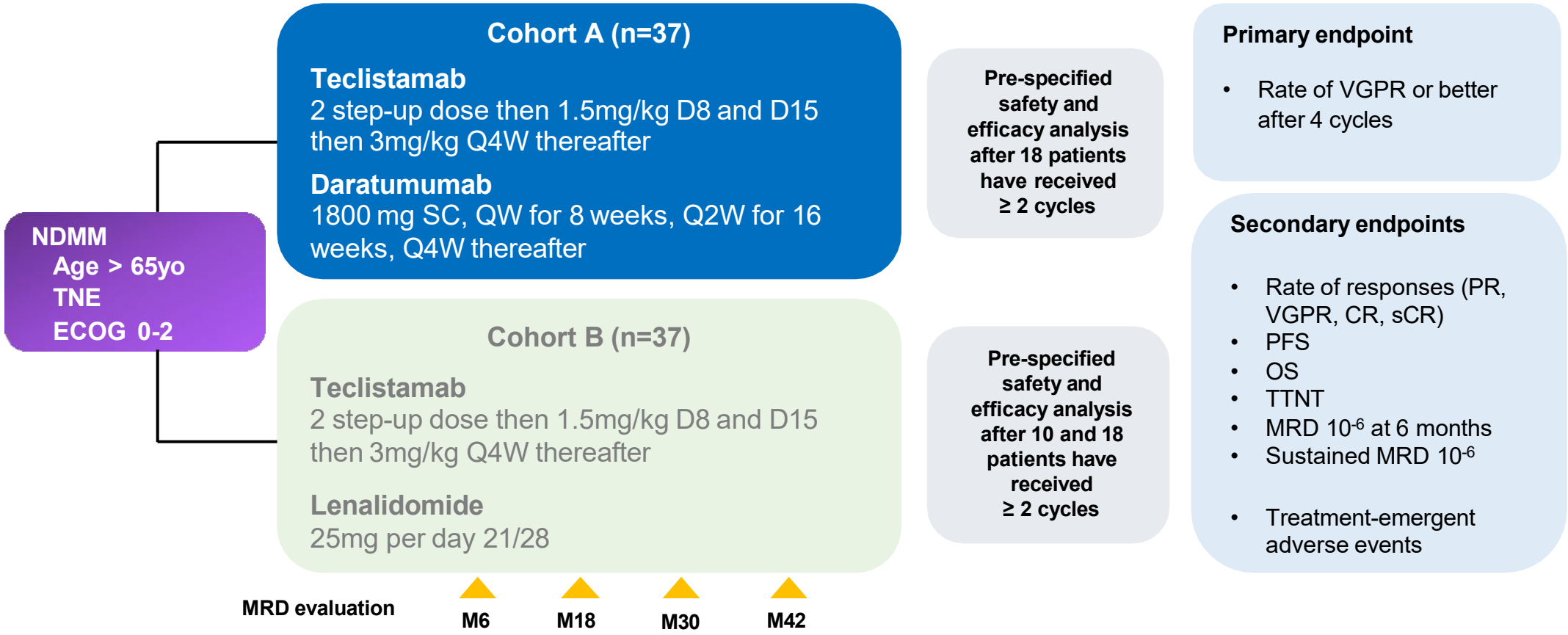
ASH 2025, Orlando

ifm

CHU LILLE

IFM 2021-01 TecLille - Study design

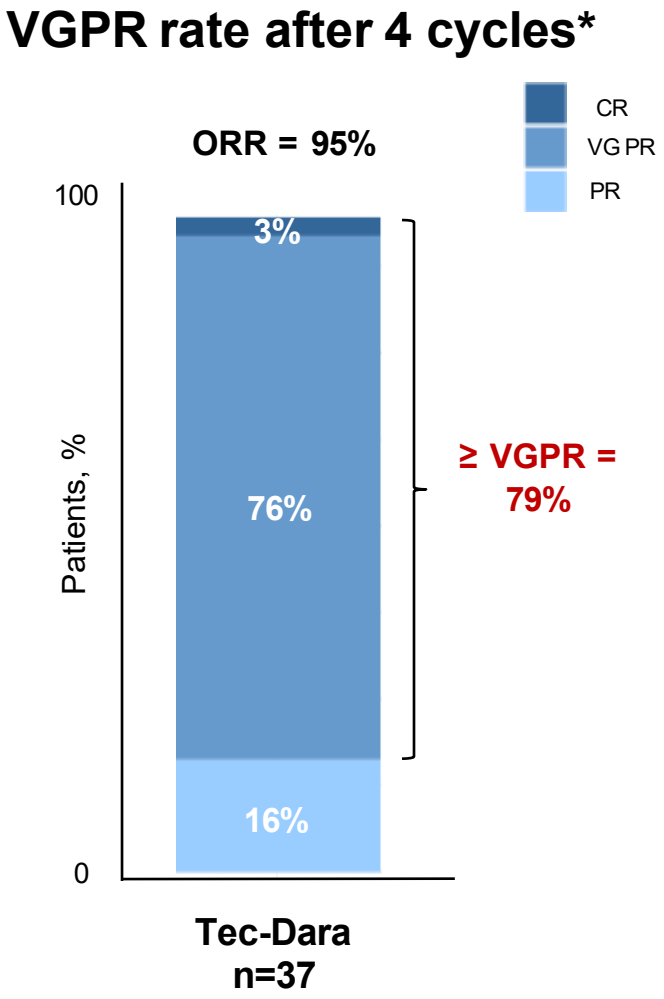
Phase 2 study of Tec-Dara and Tec-Len in TNE NDMM (n = 74)

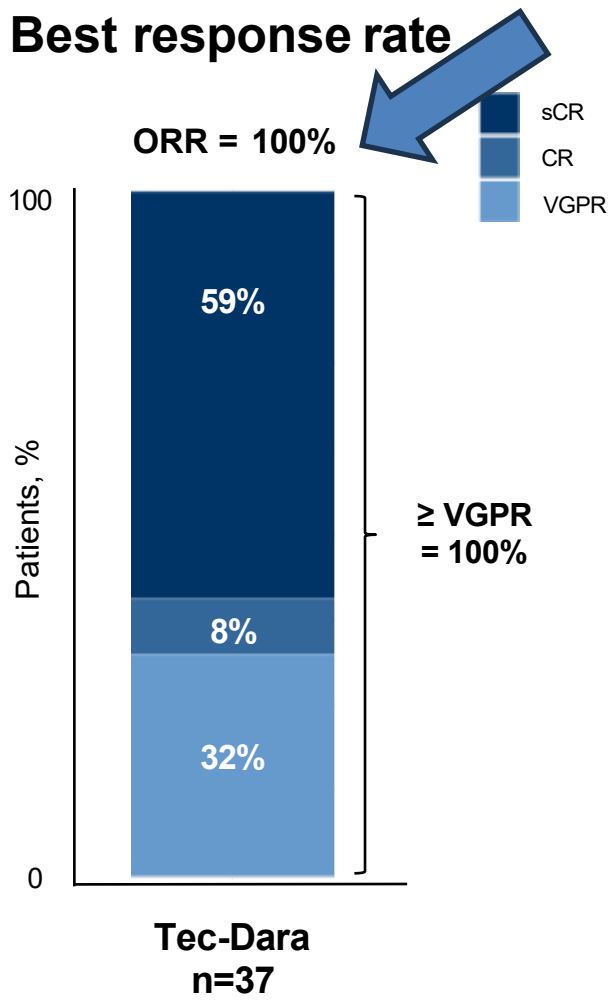


Current amendment:
Teclistamab 3mg/kg Q8W after C13 if CR or better and treatment interruption if 2-years sustained MRD -

NCT05572229

IFM 2021-01 TecLille – cohort A: Tec-Dara Response rates





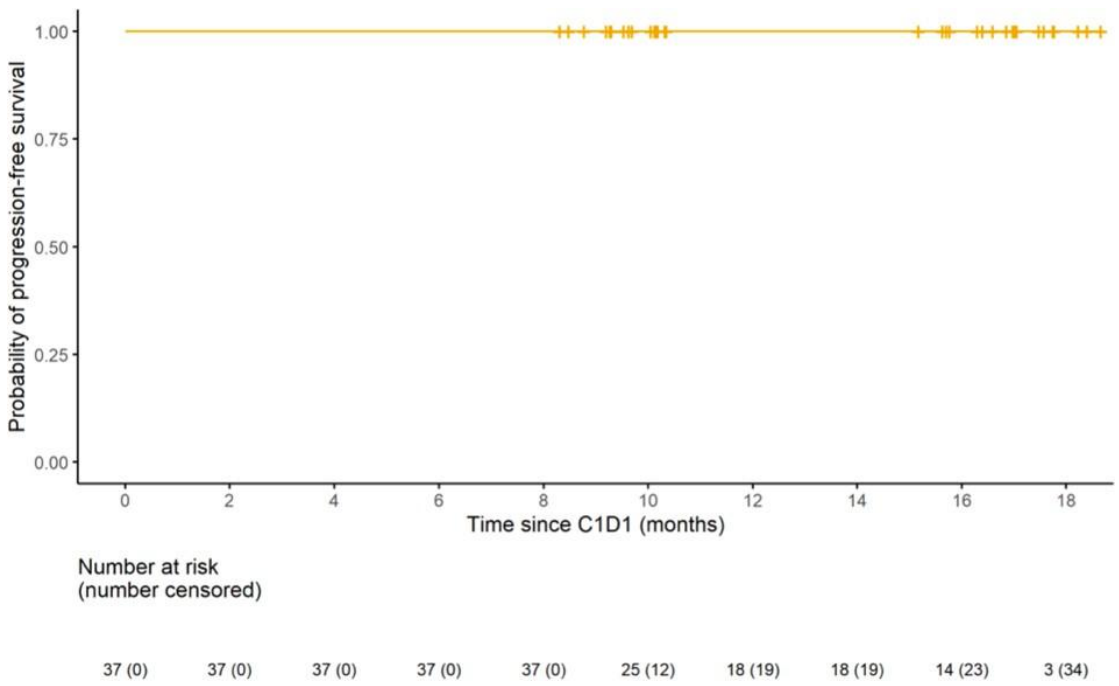
* primary endpoint

All patients achieved VGPR or better at best response

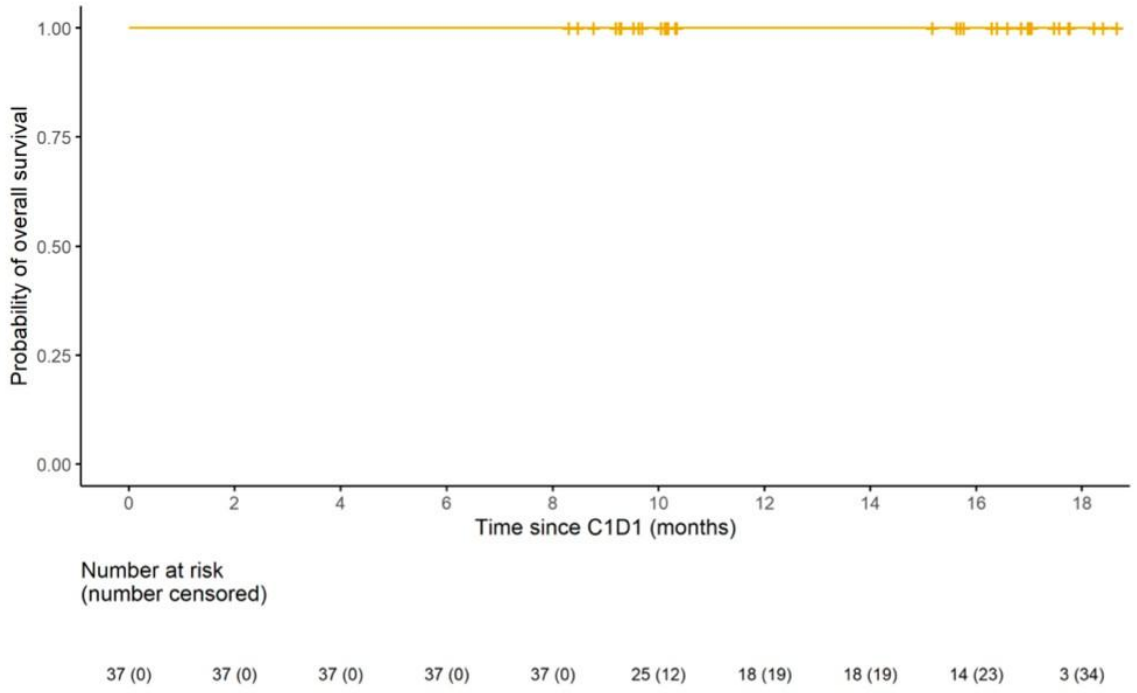
IFM 2021-01 TecLille – cohort A: Tec-Dara PFS and OS

Median follow up time = 10.3 months

PFS



OS



No event of progression or death occurred

Publication Number: 258

A Dual Targeting BCMA and CD19 FasTCAR-T (GC012F/AZD0120) as First-line Therapy for Newly Diagnosed Multiple Myeloma

Juan Du,*[1] Wanting Qiang,[1] Jing Lu,[1] Yanchun Jia,[1] Haiyan He,[1] Jin Liu,[1] Pei Guo,[1] Ying Yang,[1] Zhongyuan Feng,[1] Lina Jin,[1] Xiaoqiang Fan,[1] Nina Shah,[2] Qi Zhang,[3] Lianjun Shen,[3] Jia Liu[3]

[1]Department of Hematology, Myeloma & Lymphoma Center, Shanghai Changzheng Hospital, Shanghai, China
[2]AstraZeneca, Gaithersburg, MD, USA
[3]Gracell Biotechnologies Ltd., Shanghai, China

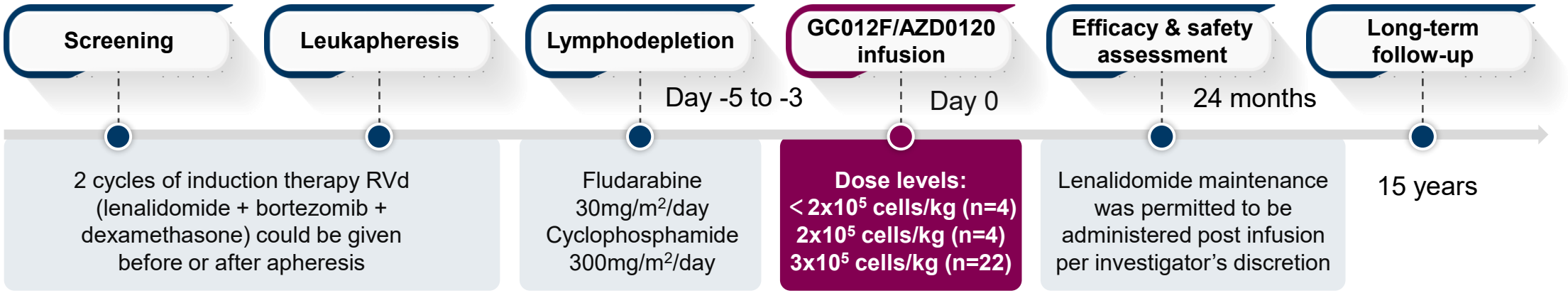
Study design
Two Phase 1 studies in NDMM

Key eligibility criteria

- Diagnosed with MM per IMWG criteria
- ECOG PS ≤3
- Measurable disease
- **Study 1 (NCT04935580): high risk (HR)* transplant eligible (TE) NDMM (N=22)**
- **Study 2 (NCT05840107): transplant ineligible (TI) NDMM (N=8)**

Key endpoints

- **Safety:** incidence and severity of Aes
- **Efficacy:** ORR, per 2016 IMWG criteria
- CRR; MRD negativity rate
- DoR, OS, PFS



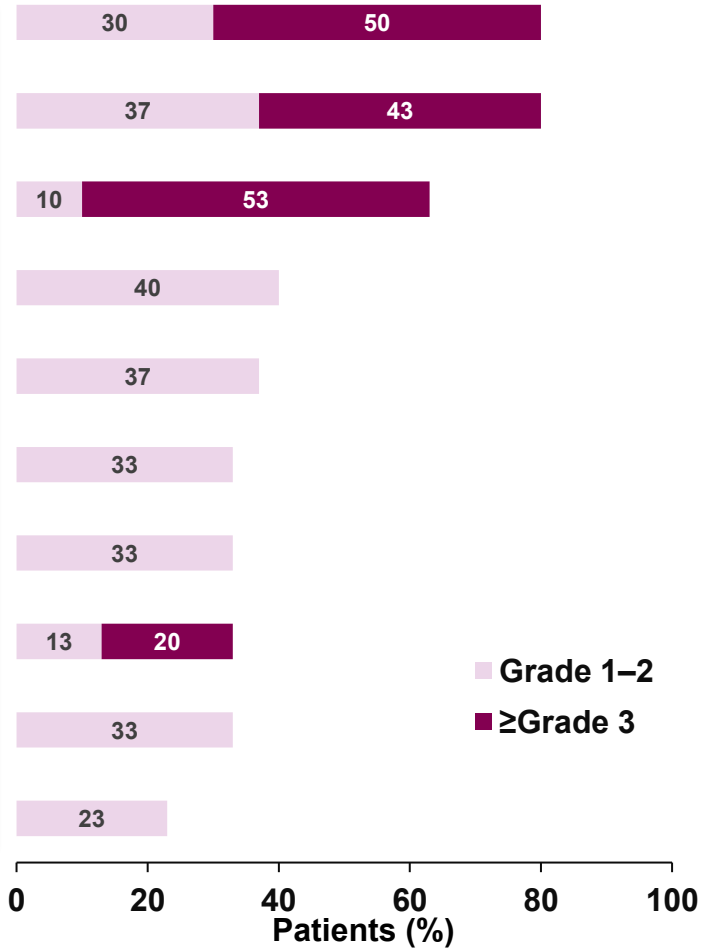
* High-risk was defined as meeting at least one of the following: a) R-ISS stage II or III; b) High-risk cytogenetics: del17p, t(4;14), t(14;16), or 1q21 ≥4 copies; c) Extramedullary disease; d) IgD or IgE subtype; e) High-risk definition according to mSMART3.0; f) LDH > the upper limit of normal.

IMWG: International Myeloma Working Group; ECOG PS: Eastern Cooperative Oncology Group Performance Status; AE: A22erse events; ORR: Overall response Rate; CRR: Complete Response Rate; MRD: Minimal Residual Disease; PFS: Progression Free Survival; DOR: Duration of Response: OS: Overall Survival.

Safety profile: TEAEs

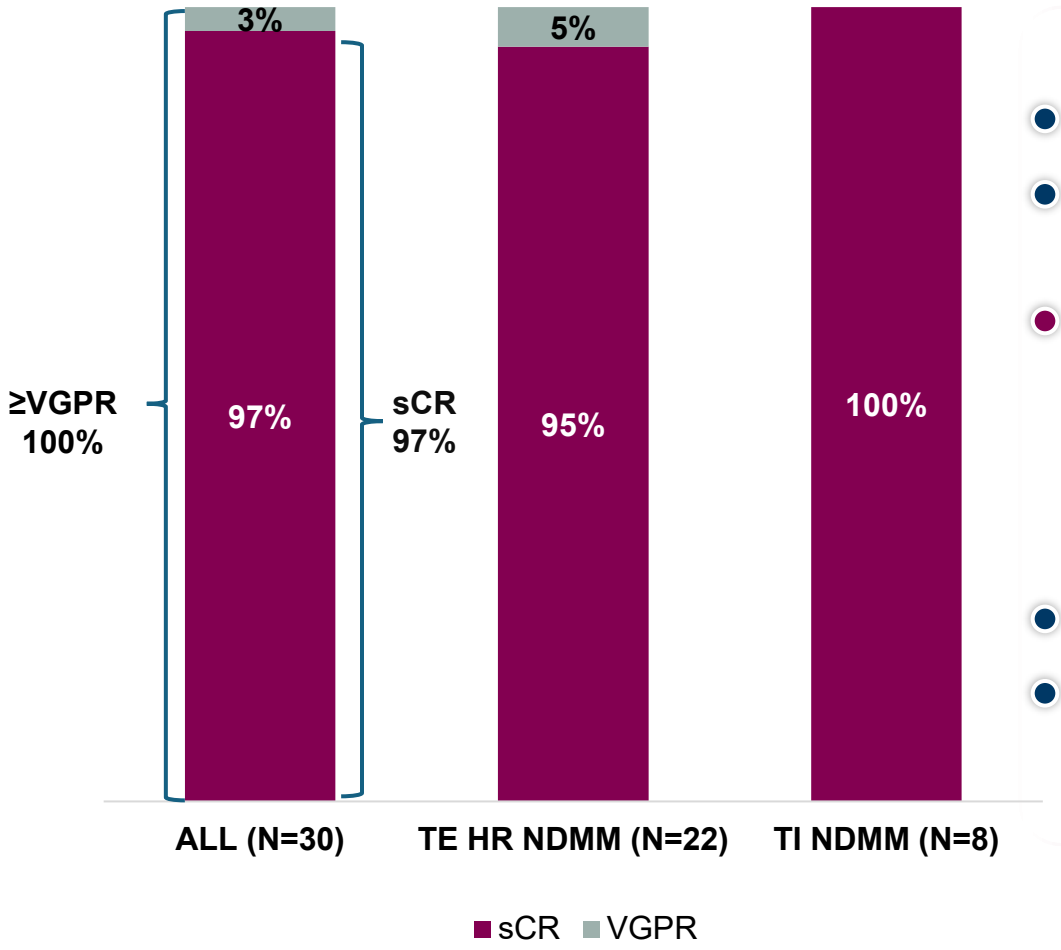
- GC012F was well tolerated and mostly low-grade CRS
- Grade 1 CRS: 30% (9/30), grade 2 CRS: 3% (1/30), grade ≥3 CRS: 0
  - Four patients with CRS were treated with tocilizumab
  - Median time to onset: 8 days (range, 6–18 days)
  - Median duration: 2 days (range, 1–8 days)
- No ICANS or IEC-HS or IEC-EC observed
- No delayed neurotoxicities or secondary primary malignancies observed to date

TEAEs, n (%)	All grades	Grade ≥3
Neutropenia	24 (80)	15 (50)
Leukopenia	24 (80)	13 (43)
Lymphopenia	19 (63)	16 (53)
LDH increased	12 (40)	0
Thrombocytopenia	11 (37)	0
Hypoalbuminemia	10 (33)	0
Anemia	10 (33)	0
Infection	10 (33)	6 (20)
CRS	10 (33)	0
Hypocalcemia	7 (23)	0



AEs were graded according to CTCAE v5.0.
AE, adverse event; ASTCT, American society for transplantation and cellular therapy; CRS, cytokine release syndrome, graded by ASTCT consensus; CTCAE, common terminology criteria for adverse events; ICANS, immune effector cell-associated neurotoxicity syndrome, graded by ASTCT consensus; IEC-EC, immune effector cell–associated encephalopathy; IEC-HS, immune effector cell–associated hemophagocytic syndrome; LDH, lactase dehydrogenase; TEAE, treatment-emergent adverse event.

100% ORR in both cohorts

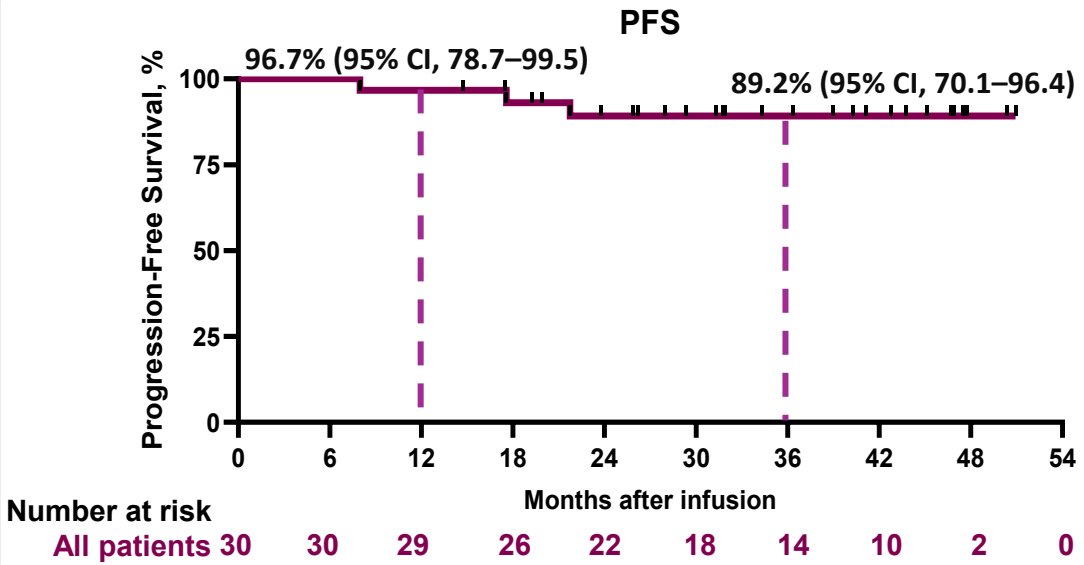


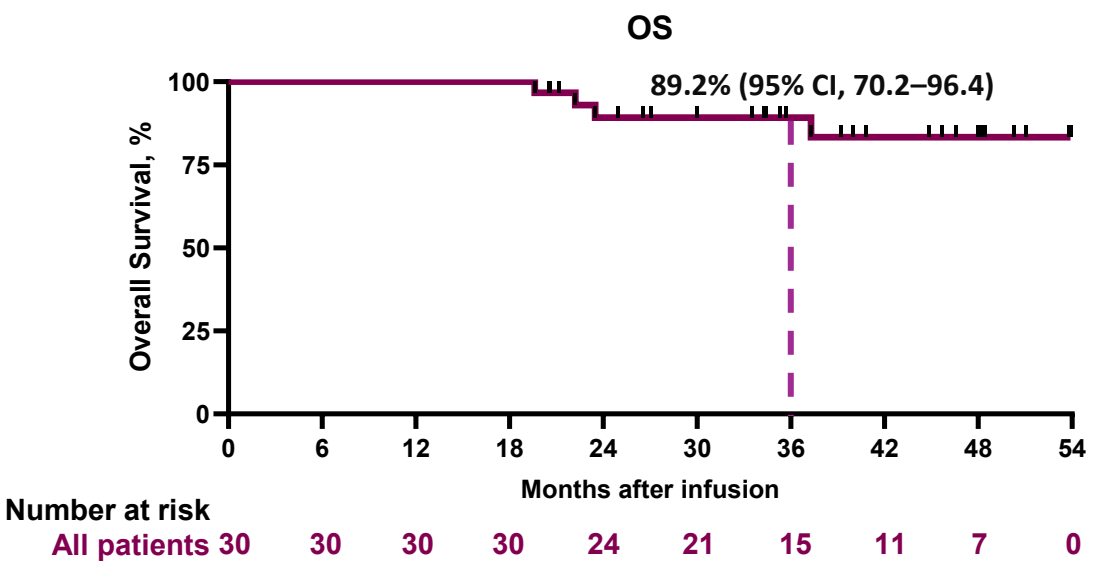
- Fast and deep responses were achieved in both groups
- As of October 15, 2025, the median follow-up time since diagnosis was 36.5 months (19.6–53.9)
- **ORR=100% (30/30):**
  - **100% ≥VGPR**
  - **97% (29/30)** sCR (1 VGPR patient still in response)
- Median time to first response post infusion was 28 days
- Median time to best response post infusion was 68 days

HR, high risk; NDMM, newly diagnosed multiple myeloma; ORR, overall response rate; sCR, stringent complete response; TE, transplant eligible; TI, transplant ineligible; VGPR, very good partial response.

Efficacy profile: PFS & OS

Median study follow-up: 36.5 months





- **No patients died within 12 months of AZD0120 infusion**
- **23 patients (77%) received lenalidomide maintenance (median time to initiation was 6 months post infusion)**
  - Two patients progressed and then died
- **7 patients did not receive lenalidomide maintenance, 5 of them remain in disease-free survival.**
  - One experienced PD and subsequently died
  - One died without documented PD

OS, overall survival; PD, progressive disease; PFS, progression-free survival.

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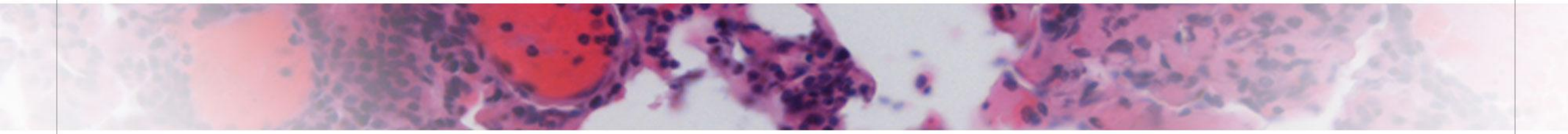


A Phase 2 Trial of Abbreviated Fixed-Duration (Default 4 Cycles) Linvoseltamab Immuno-Consolidation to Deepen Responses Post Newly Diagnosed Multiple Myeloma Combination Therapy for Minimal Residual Disease Positivity (NCT06376526): The ***IMMUNOPLANT™*** Study

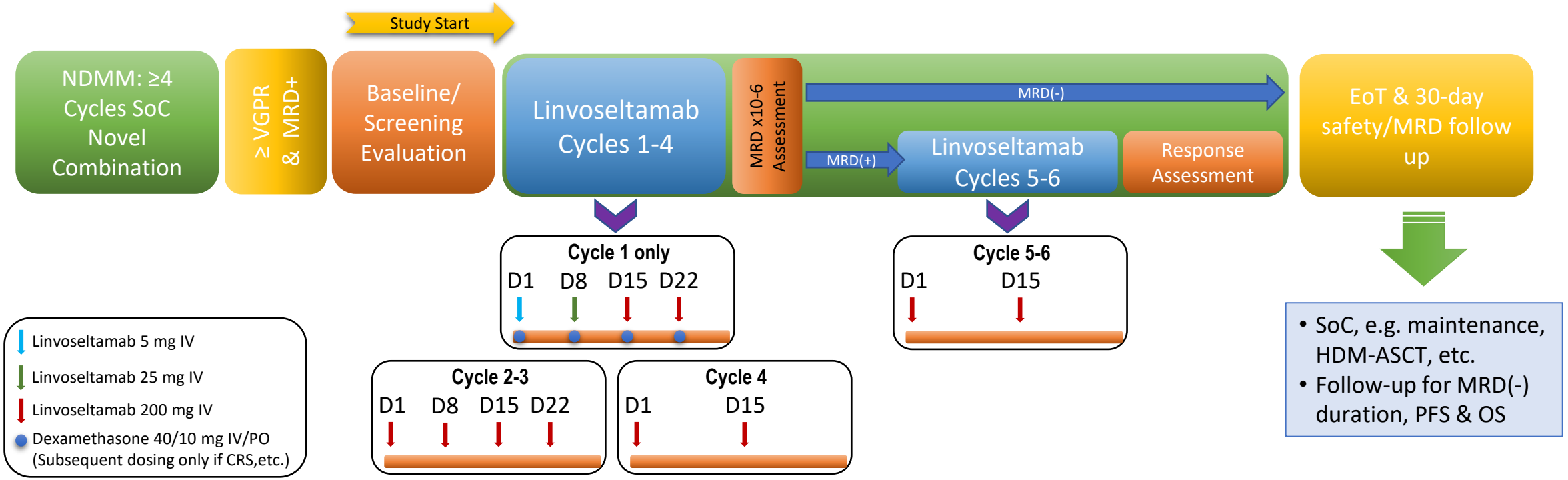
Dickran Kazandjian*, Benjamin Diamond, James Hoffman, Abhishek Pandey, David Coffey, Marcella Kaddoura, Brian Walker, David Lessen, Yaharini, Rodriguez, Caterine Diaz, Stephanie Mompoint, Sindy Gutierrez, Jennifer Chapman, Yi Zhou, Mike Georgiou, Russ Kuker, Kellye Koubek, Andrew Kowalski, Leslie Gallardo, Stephanie Fernandes, Fiorela Flores, Rabia Bukhari, Sunwoo Han, Michelle Armogan, **Ola Landgren**

*Email: dkazandjian@miami.edu

SYLVESTER COMPREHENSIVE CANCER CENTER
UNIVERSITY OF MIAMI HEALTH SYSTEM
MYELOMA INSTITUTE

Study Design: Schema

Immuno-consolidation for newly diagnosed **M**ultiple **M**yeloma **U**sing lack of MRD **N**egativity after initial c**O**mbination therapy to **P**ursue deeper responses with **L**invoseltamab **AN**d delay **T**ransplant:
The Phase 2 **IMMUNOPLANT™ Study**)



Key Eligibility
–PI/IMiD/anti-CD38 triplet/quad
–≥4 cycles with MRD+ ≥VGPR
–adequate organ function

Statistical Hypothesis:
- Simon Minimax 2-Stage Design: Target MRD(-) Rate: 30%; null MRD(-) Rate: 10%
- Stage I: ≥2 of 15 patients with response--> continue enrollment
- Stage II: total ≥6 of 25 patients with response→ reject null hypothesis
- One sided alpha = 0.05; Power = 80%

Endpoints:
Primary: MRD- 10^{-6}conversion rate
Secondary: Safety, sustained MRD negativity, PFS, OS

Brief Takeaways on Frontline Therapy

1. Single agent daratumumab is a legitimate option in high-risk smoldering myeloma using the 20/2/20 criteria

2. Quadruplets remain the standard of care in frontline MM with sustained responses

3. Teclistamab can be feasibly and effectively given in frontline myeloma in combination with daratumumab, even in the frail population

4. CAR T cell therapy frontline-in this case, dual targeting, is still early in development but with remarkable efficacy and safety

5. Novel approaches to achieve MRD negativity include adding fixed duration bispecific antibody therapy post induction

Early Relapse

1. Teclistamab-Dara in early relapse (LBA-6)
2. Long term follow up cilta-cel (#94)
3. Enhancing safety of cilta-cel (#1034)
4. Elranatamab plus Iberdomide (#100)
5. Functional High-Risk Definition (#1037)

Phase 3 Randomized Study of Teclistamab Plus Daratumumab Versus Investigator's Choice of Daratumumab and Dexamethasone With Either Pomalidomide or Bortezomib (DPd/DVd) in Patients With Relapsed Refractory Multiple Myeloma (RRMM): Results of MajesTEC-3

Maria-Victoria Mateos,[1] Nizar J. Bahlis,[2] Aurore Perrot,[3] Ajay K. Nooka,[4] Jin Lu,[5] Charlotte Pawlyn,[6,7] Roberto Mina,[8] Gaston Caeiro,[9] Alain Kentos,[10] Vania Hungria,[11] Donna Reece,[12] Ting Niu,[13] Anne K. Mylin,[14] Charlotte Toftmann Hansen,[15] Raphael Teipel,[16] Britta Besemer,[17] Meletios A. Dimopoulos,[18,19] Elena Zamagni,[20,21] Satoshi Yoshihara,[22] Kihyun Kim,[23] Chang Ki Min,[24] Paul Geerts,[25] Elena Van Leeuwen-Segarceanu,[26] Agata Tyczynska,[27] Juan Luis Reguera Ortega,[28] Magnus Johansson,[29] Markus Hansson,[30] Mehmet Turgut,[31] Mark Grey,[32] Surbhi Sidana,[33] Paula Rodriguez-Otero,[34] Joaquin Martinez-Lopez,[35] Hamza Hashmi,[36] Robin Carson,[37] Rachel Kobos,[38] Weili Sun,[39] Kristen Lantz,[37] Anne Seifert,[40] Deborah Briseno-Toomey,[41] Lisa O'Rourke,[37] Maria Rubin,[38] Diego Vieyra,[37] Lijuan Kang,[39] Luciano J. Costa[42]

[1]Hospital Universitario de Salamanca, Instituto de Investigación Biomédica de Salamanca, Instituto de Biología Molecular y Celular del Cáncer (Universidad de Salamanca-Consejo Superior de Investigaciones Científicas), CIBERONC, Salamanca, Spain; [2]Arnie Charbonneau Cancer Institute, University of Calgary, Calgary, AB, Canada; [3]Universite de Toulouse, Centre Hospitalier Universitaire, Service d'Hematologie, IUCT Oncopole CRCT, Toulouse, France; [4]Emory University, Winship Cancer Institute, Atlanta, GA, USA; [5]Peking University People's Hospital, Peking University Institute of Hematology, National Clinical Research Center for Hematologic Disease, Beijing, China; [6]The Royal Marsden NHS Foundation Trust, London, UK; [7]The Institute of Cancer Research, London, UK; [8]AOU Città della Salute e della Scienza di Torino, University of Torino, Torino, Italy; [9]Hospital Privado Universitario de Córdoba – Instituto Universitario de Ciencias Biomédicas de Córdoba, Córdoba, Argentina; [10]Hôpital de Jolimont, Haine-Saint-Paul, Belgium; [11]Clinica São Germano, São Paulo, Brazil; [12]Princess Margaret Cancer Centre, Toronto, ON, Canada; [13]West China Hospital, Sichuan University, Chengdu, China; [14]Rigshospitalet, Copenhagen, Denmark; [15]Odense University Hospital, Odense, Denmark; [16]Medizinische Klinik und Poliklinik I Universitätsklinikum Carl Gustav Carus an der Technischen Universität Dresden, Dresden, Germany; [17]University Tübingen, Tübingen, Germany; [18]National and Kapodistrian University of Athens, School of Medicine, Athens, Greece; [19]Korea University, Seoul, South Korea; [20]IRCCS Azienda Ospedaliero-Universitaria di Bologna, Istituto di Ematologia "Seràgnoli," Bologna, Italy; [21]Università di Bologna, Bologna, Italy; [22]Hyogo Medical University Hospital, Nishinomiya, Japan; [23]Sungkyunkwan University School of Medicine, Samsung Medical Center, Seoul, Korea; [24]Seoul St. Mary's Hospital, The Catholic University of Korea, Seoul, Korea; [25]Isala Klinieken, Zwolle, The Netherlands; [26]St. Antonius Hospital Nieuwegein, Nieuwegein, The Netherlands; [27]Medical University of Gdansk; University Clinical Center, Gdansk, Poland; [28]University Hospital Virgen del Rocío, Instituto de Biomedicina de la Universidad de Sevilla, Seville, Spain; [29]Medicinkliniken, Sunderby Sjukhus, Luleå, Sweden; [30]Sahlgrenska University Hospital, Göteborg, Sweden; [31]Ondokuz Mayis University, Samsun, Turkey; [32]The Lancashire Haematology Centre, Blackpool Teaching Hospitals NHS Foundation Trust, Blackpool Victoria Hospital, Blackpool, UK; [33]Stanford University School of Medicine, Palo Alto, CA, USA; [34]Cancer Center Clínica Universidad de Navarra, University of Navarra, Pamplona, Spain; [35]Hospital 12 de Octubre, i+12, Universidad Complutense, MIC, Centro Nacional de Investigaciones Oncológicas, CIBERONC, Madrid, Spain; [36]Memorial Sloan Kettering Cancer Center, New York, NY, USA; [37]Johnson & Johnson, Spring House, PA, USA; [38]Johnson & Johnson, Raritan, NJ, USA; [39]Johnson & Johnson, Los Angeles, CA, USA; [40]Johnson & Johnson, High Wycombe, UK; [41]Johnson & Johnson, Yorba Linda, CA, USA; [42]University of Alabama at Birmingham, Birmingham, AL, USA.

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https://www.congresshub.com/ASH2025/Oncology/Teclistamab/Mateos-LBA

MajesTEC-3: Phase 3 Study Design

Key inclusion criteria

- RRMM
- 1-3 prior LOTs including a PI and lenalidomide
  - Patients with only 1 prior LOT must have been lenalidomide refractory per IMWG criteria
- ECOG PS score of 0-2

Key exclusion criteria

- Prior BCMA-directed therapy
- Refractory to anti-CD38 mAbs[a]

1:1 randomization N=587

22 Oct 2021 to 29 Sept 2023[b]

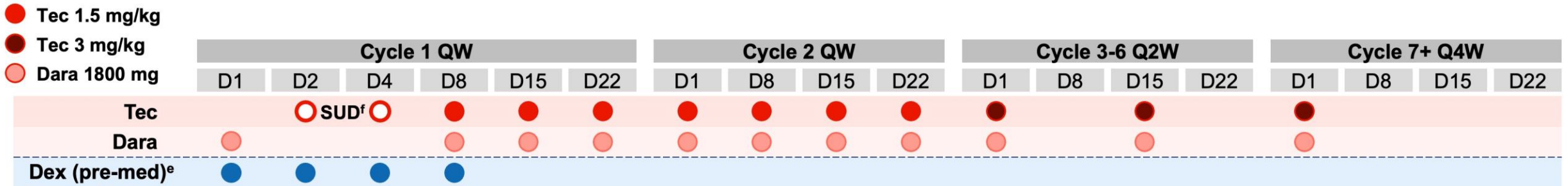
Tec-Dara
N=291
SC dosing following Dara schedule

DPd/DVd
N=296 (91% DPd)
by investigator's choice[c]

Primary endpoint
- PFS per IRC

Key secondary endpoints
- ≥CR[d] and ORR[d]
- MRD negativity (10^{-5})
- OS
- MySIm-Q Total Symptom score

Other secondary endpoints
- Safety
- PK and immunogenicity



SC dosing aligned with Dara schedule, with monthly dosing after 6 cycles; steroid sparing after Cycle 1 Day 8

[a]Prior exposure to anti-CD38 mAbs was permitted. [b]During the COVID-19 pandemic. [c]DPd/DVd were administered per the approved schedules. [d]Response and disease progression were assessed by a blinded IRC per IMWG criteria. [e]Dexamethasone, acetaminophen, and diphenhydramine pre-medication was required for the first 2 weeks; subsequent dexamethasone was not required thereafter. [f]Patients received SUD of 0.06 mg/kg and 0.3 mg/kg on Days 2 and 4, respectively.

CR, complete response; D, day; Dex, dexamethasone; DPd, daratumumab, pomalidomide, and dexamethasone; DVd, daratumumab, bortezomib, and dexamethasone; ECOG PS, Eastern Cooperative Oncology Group performance status; IMWG, International Myeloma Working Group; IRC, independent review committee; MRD, minimal residual disease; MySIm-Q, Multiple Myeloma Symptom and Impact Questionnaire; ORR, overall response rate; PFS, progression-free survival; PI, proteasome inhibitor; PK, pharmacokinetics; pre-med, pre-medication; QW, weekly; Q2W, every 2 weeks; Q4W, every 4 weeks; SC, subcutaneous; SUD, step-up dosing.

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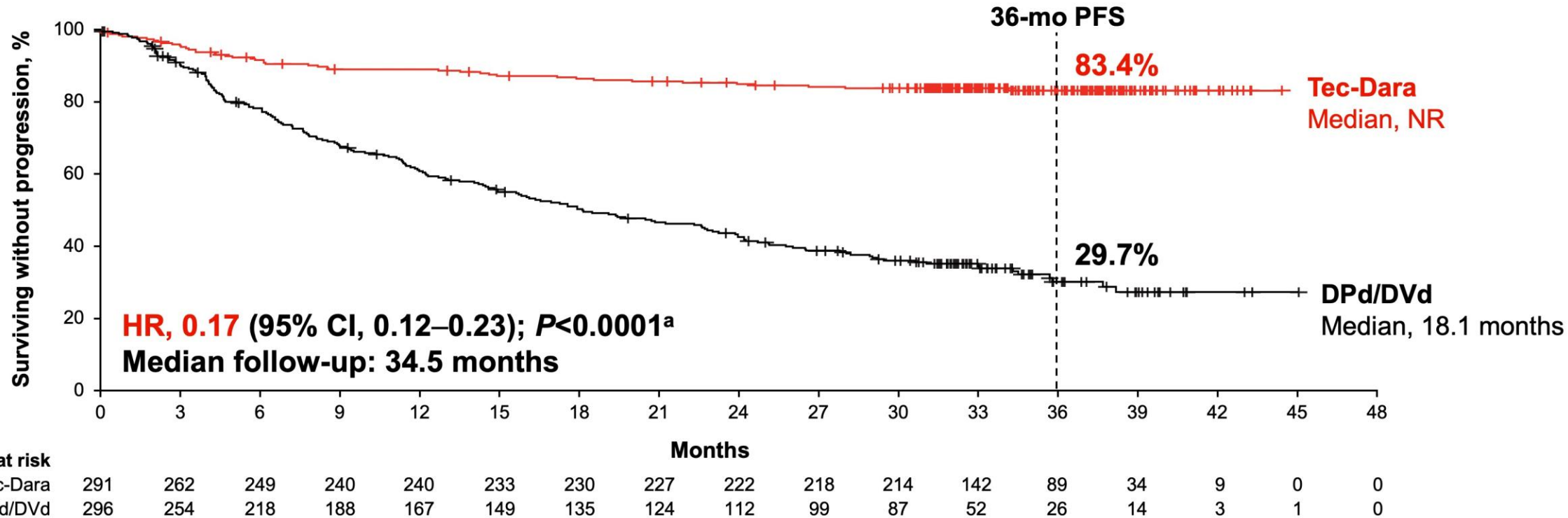
MajesTEC-3: PFS (Primary Endpoint)



Tec-Dara significantly improved PFS, with a plateauing curve after ~6 months and >90% of patients progression-free at 6 months sustaining such a benefit at 3 years

[a]The *P* value crossed the prespecified stopping boundary for superiority for the first interim analysis (*P*=0.0139).
CI, confidence interval; HR, hazard ratio; NR, not reached.

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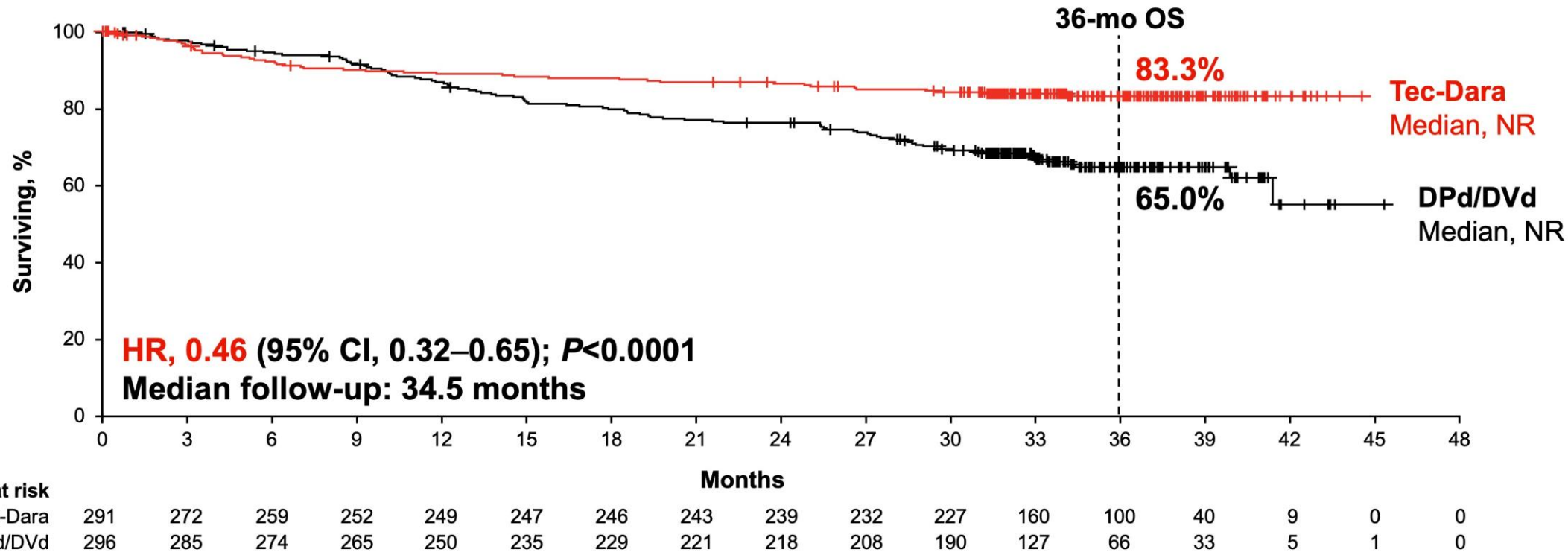
MajesTEC-3: OS



No. at risk																	
Tec-Dara	291	272	259	252	249	247	246	243	239	232	227	160	100	40	9	0	0
DPd/DVd	296	285	274	265	250	235	229	221	218	208	190	127	66	33	5	1	0

Tec-Dara significantly improved OS versus DPd/DVd, with 83% of patients alive at 3 years

Analysis of RMST demonstrated an OS benefit for Tec-Dara versus DPd/DVd (RMST difference, 2.15 months; *P*=0.0088).
RMST, restricted mean survival time.

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MajesTEC-3: Summary of Infections

- Study started during the COVID-19 pandemic and prior to bispecific treatment guidelines
- Hypogammaglobulinemia[a]: 84.5% with Tec-Dara
- 13 (4.6%) deaths due to infection with Tec-Dara[b]
  - 12 occurred within 6 months of treatment (3 due to COVID-19); 9 of 12 patients did not receive IgRT
  - Protocol was subsequently amended in Feb 2023 to reinforce IgRT supplementation and antimicrobial prophylaxis[c]
    - 87.3% received ≥1 dose of Ig[d]
    - 1 infectious death occurred post amendment

TEAE, n (%)	Tec-Dara (n=283)		DPd/DVd (n=290)	
	Any grade	Grade 3/4	Any grade	Grade 3/4
Any infection	273 (96.5)	153 (54.1)	244 (84.1)	126 (43.4)
Treatment-emergent infection or infestation[e]				
COVID-19	124 (43.8)	17 (6.0)	97 (33.4)	6 (2.1)
URTI	115 (40.6)	12 (4.2)	88 (30.3)	7 (2.4)
Pneumonia	65 (23.0)	47 (16.6)	53 (18.3)	43 (14.8)
Nasopharyngitis	62 (21.9)	0	57 (19.7)	0
Sinusitis	52 (18.4)	5 (1.8)	17 (5.9)	3 (1.0)
Rhinovirus infection	44 (15.5)	5 (1.8)	10 (3.4)	1 (0.3)
Bronchitis	40 (14.1)	2 (0.7)	31 (10.7)	6 (2.1)
Influenza	38 (13.4)	8 (2.8)	43 (14.8)	10 (3.4)
COVID-19 pneumonia	34 (12.0)	32 (11.3)	12 (4.1)	7 (2.4)
UTI	29 (10.2)	4 (1.4)	27 (9.3)	1 (0.3)

Infections with Tec-Dara require diligent use of established IgRT and prophylaxis protocols

[a]Hypogammaglobulinemia was defined as patients with ≥1 TEAE of hypogammaglobulinemia or a post-baseline IgG value <400 mg/dL. Rate of hypogammaglobulinemia in the DPd/DVd arm was 60.3%. [b]In the DPd/DVd group, 4 patients had a fatal infection, 2 of which occurred after the implementation of protocol amendment #6. [c]Protocol amendment #6 affirmed the importance of medical monitoring of IgG levels and adherence to protocol-specified Ig supplementation guidance. [d]Percentage at clinical cutoff. [e]Most common defined as occurring in ≥10% of patients in either treatment group; shown with percent occurrence of respective grade 3/4 infection.
Ig, immunoglobulin; IgG, immunoglobulin G; IgRT, immunoglobulin replacement therapy; UTI, urinary tract infection.

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Long-Term Progression-Free Survival Benefit With Ciltacabtagene Autoleucel in Standard-Risk Relapsed/Refractory Multiple Myeloma

Luciano Costa[1], Albert Oriol[2], Dominik Dytfeld[3], Salomon Manier[4], Peter Voorhees[5], Yi Lin[6], Myo Htut[7], Wilfried Roeloffzen[8], Phoebe Joy Ho[9], Urvi Shah[10], Man Zhao[11], Quanlin Li[12], Agnes Balogh[13], Katherine Li[14], Ana Slaughter[15], Nina Benachour[13], Carolina Lonardi[16], Arnab Ghosh[17], Huabin Sun[17], Nikoletta Lendvai[17], Tamar Lengil[17], Nitin Patel[18], Mythili Koneru[18], Erika Florendo[18], Octavio Costa[18], Vrinda Mahajan[18], Paula Rodríguez-Otero[19], Christopher Strouse[20], A. Keith Stewart[21], Surbhi Sidana[22]

[1]University of Alabama at Birmingham, Birmingham, AL, United States; [2]Institut Català d'Oncologia and Institut Josep Carreras, Hospital Germans Trias i Pujol, Badalona, Barcelona, Spain; [3]Poznan University of Medical Sciences, Poznań, Poland; [4]University of Lille, CHU Lille, Lille, France; [5]Atrium Health/Levine Cancer Institute, Wake Forest University School of Medicine, Charlotte, NC, United States; [6]Mayo Clinic, Rochester, MN, United States; [7]Department of Hematology and Hematopoietic Cell Transplantation, City of Hope Comprehensive Cancer Center, Duarte, CA, United States; [8]Department of Hematology, University Medical Center Groningen, Groningen, Netherlands; [9]Royal Prince Alfred Hospital, Sydney, Australia; [10]Myeloma Service, Memorial Sloan Kettering Cancer Center, and Weill Cornell Medical College, New York, NY, United States; [11]IQVIA, Shanghai, China; 12Johnson & Johnson, Apex, NC, United States; [13]Johnson & Johnson, Beerse, Belgium; [14]Johnson & Johnson, Spring House, PA, United States; [15]Johnson & Johnson, Zug, Switzerland; [16]Johnson & Johnson, Buenos Aires, Argentina; [17]Johnson & Johnson, Raritan, NJ, United States; [18]Legend Biotech USA Inc, Somerset, NJ, United States; [19]Cancer Center Clínica Universidad de Navarra, Cima, Pamplona, Spain; [20]Hematology, Oncology, and Blood & Marrow Transplantation, University of Iowa, Iowa City, IA, United States; [21]University Health Network and the Princess Margaret Cancer Centre, Toronto, ON, Canada; [22]Stanford University School of Medicine, Stanford, CA, United States

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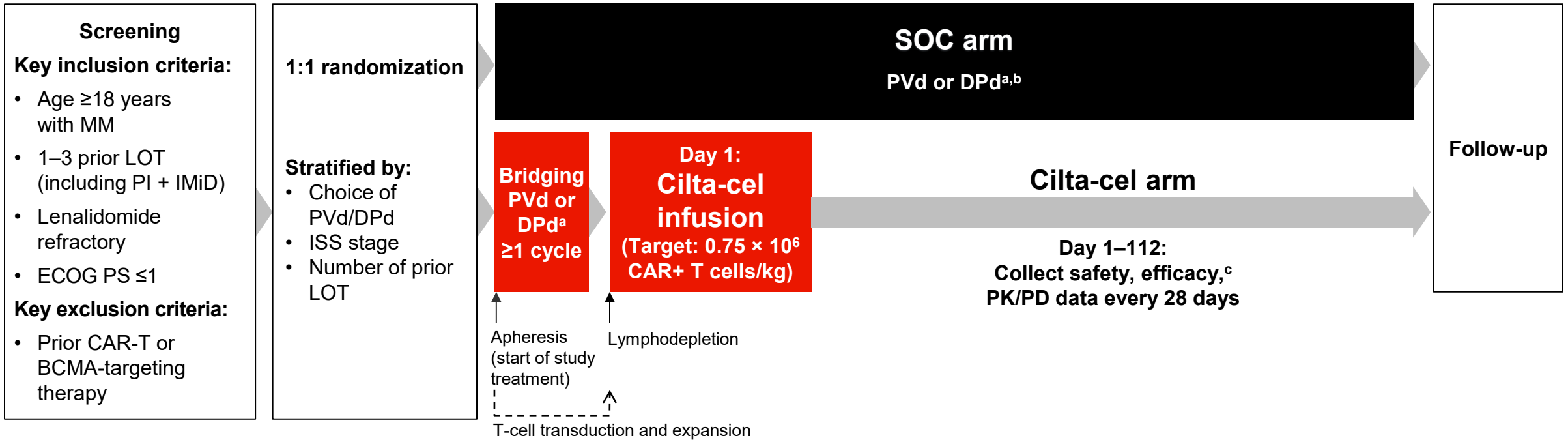
CARTITUDE-4: Study Design[1]



Primary endpoint

- PFS[d]

Secondary endpoints

- Efficacy: ≥CR, ORR, MRD negativity, OS
- Incidence and severity of AEs

[a]Physician's choice. [b]Administered until disease progression. [c]Efficacy data were collected after Day 112 every 28 days. [d]Time from randomization to disease progression/death. AE, adverse event; BCMA, B-cell maturation antigen; CAR, chimeric antigen receptor; CTCAE, Common Terminology Criteria for Adverse Events; DPd, daratumumab, pomalidomide, and dexamethasone; ECOG PS, Eastern Cooperative Oncology Group performance status; IMiD, immunomodulatory drug; ISS, International Staging System; ORR, overall response rate; PD, pharmacodynamics; PI, proteasome inhibitor; PK, pharmacokinetics; PVd, pomalidomide, bortezomib, and dexamethasone. 1. San-Miguel J, et al. *N Engl J Med* 2023;389:335-47.

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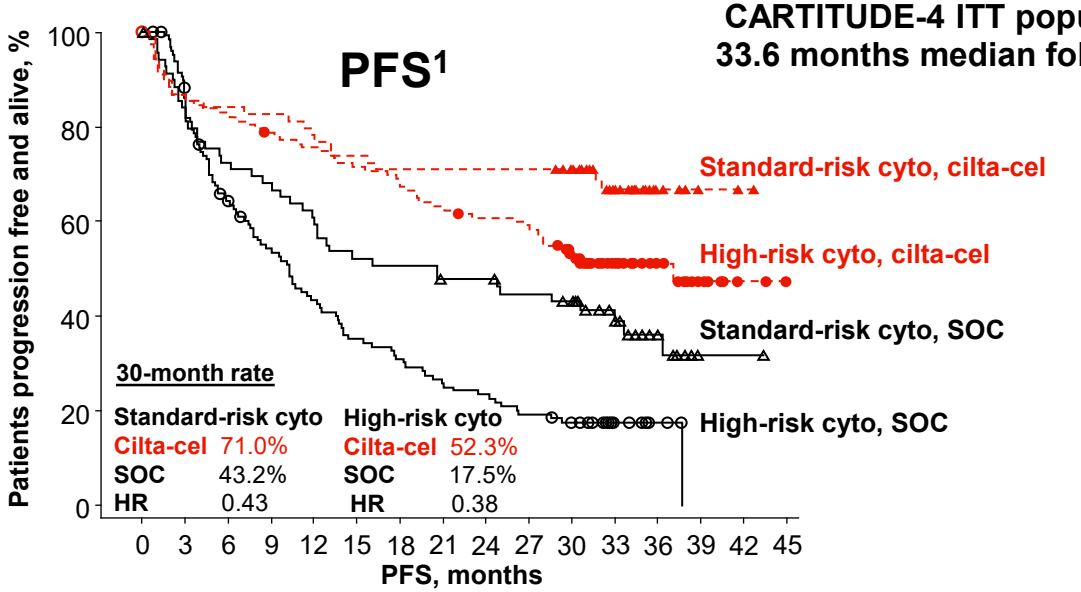
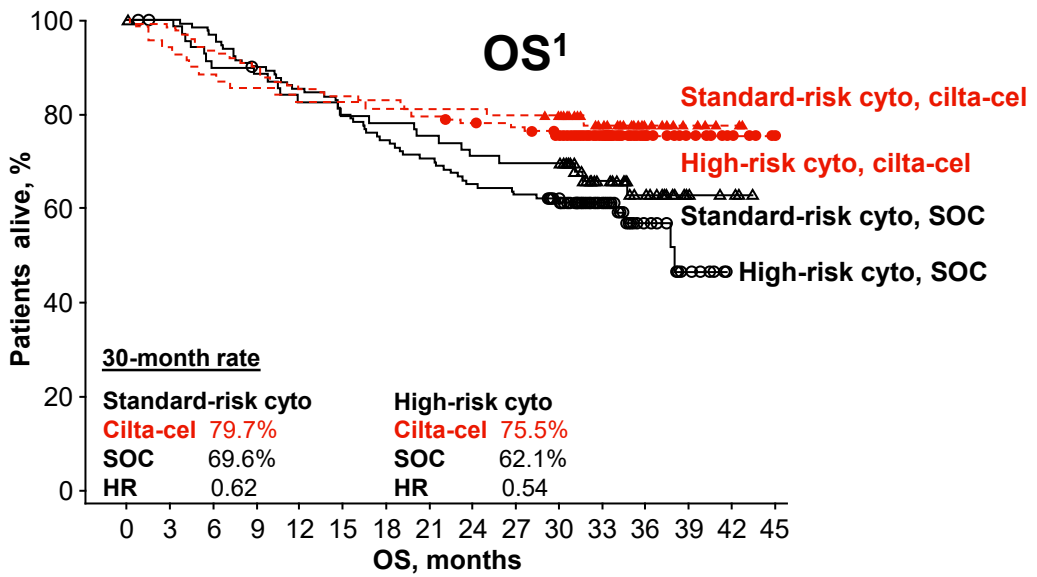
PFS and OS in Patients With High-Risk and Standard-Risk Cytogenetics (ITT)

CARTITUDE-4 ITT population
33.6 months median follow-up



Patients at risk

High risk, SOC	132	111	79	65	52	42	37	31	28	23	20	7	3	0	0	0
High risk, cilta-cel	123	106	102	96	92	87	84	76	73	70	55	31	14	7	2	0
Standard risk, SOC	70	58	50	47	41	36	35	32	32	29	27	18	9	1	1	0
Standard risk, cilta-cel	69	59	58	57	53	51	49	49	49	49	46	27	9	2	1	0



Patients at risk

High risk, SOC	132	130	126	116	110	103	96	91	84	81	75	38	14	6	0	0
High risk, cilta-cel	123	121	115	111	105	103	102	98	95	93	83	50	23	14	5	0
Standard risk, SOC	70	69	62	61	57	55	54	52	49	48	48	29	18	5	3	0
Standard risk, cilta-cel	69	65	61	59	57	57	56	56	56	55	52	35	13	5	2	0

In CARTITUDE-4, cilta-cel improved PFS and OS in prespecified subgroups with standard- and high-risk cytogenetics[1]

1. Sidana S, et al. *J Clin Oncol* 2025;43:7539.

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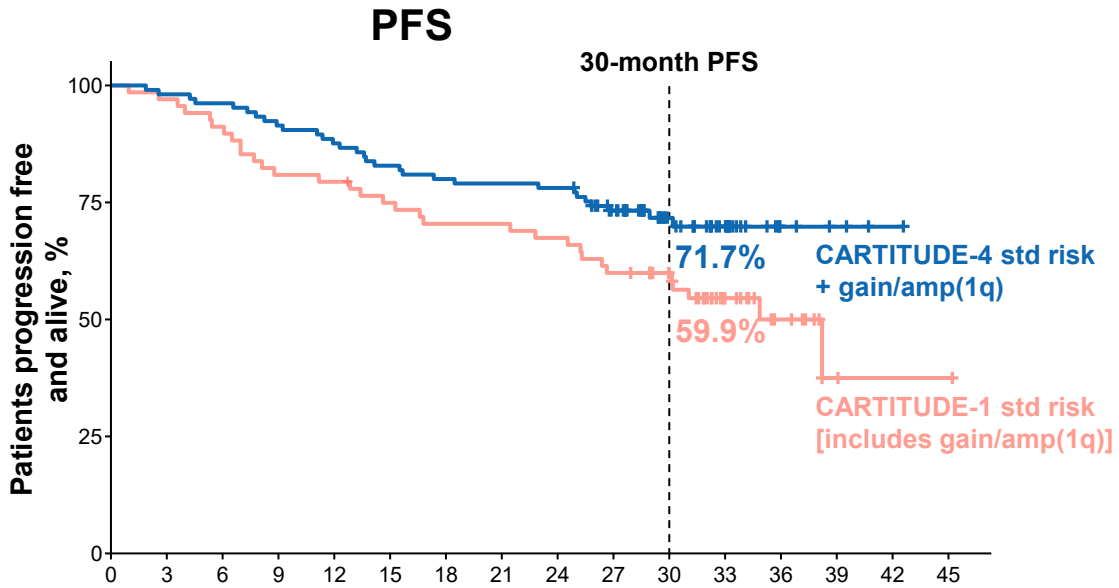
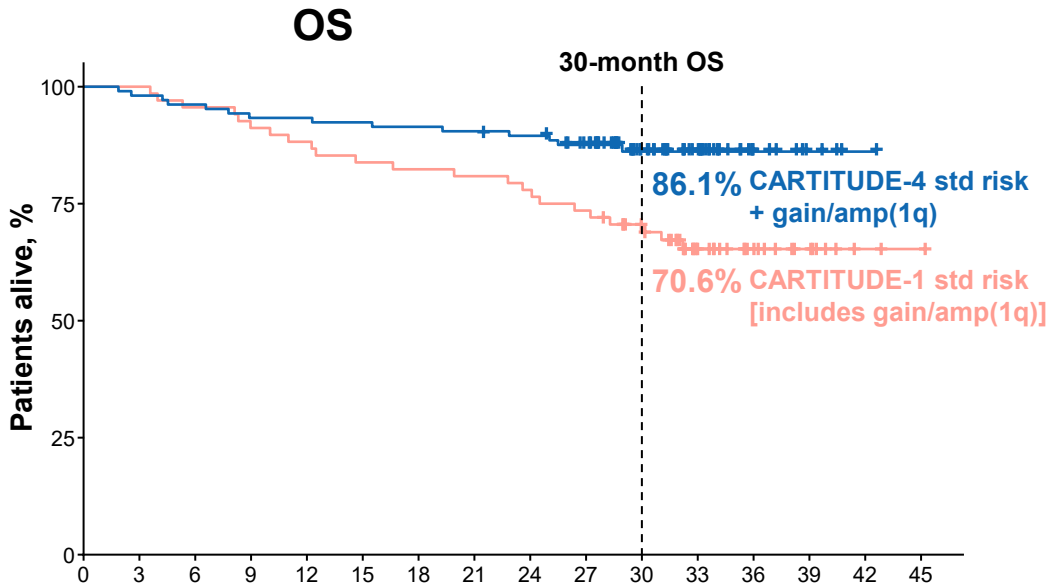
CARTITUDE-4 and CARTITUDE-1: PFS and OS in Patients With Standard-Risk Cytogenetics (As-Treated)





Survival rates were higher when cilta-cel was used earlier in standard-risk disease

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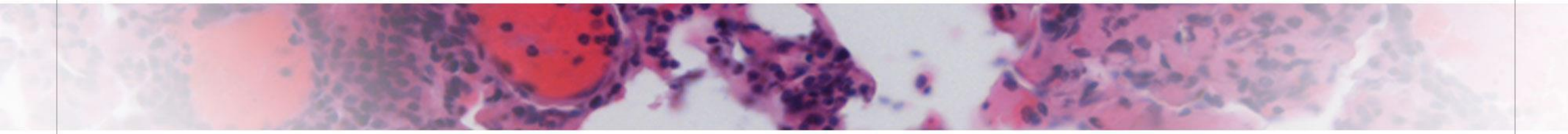


Enhancing the safety of ciltacabtagene autoleucel in relapsed multiple myeloma (MM): Identification of potentially modifiable risk-factors associated with delayed neurotoxicity and non-relapse mortality

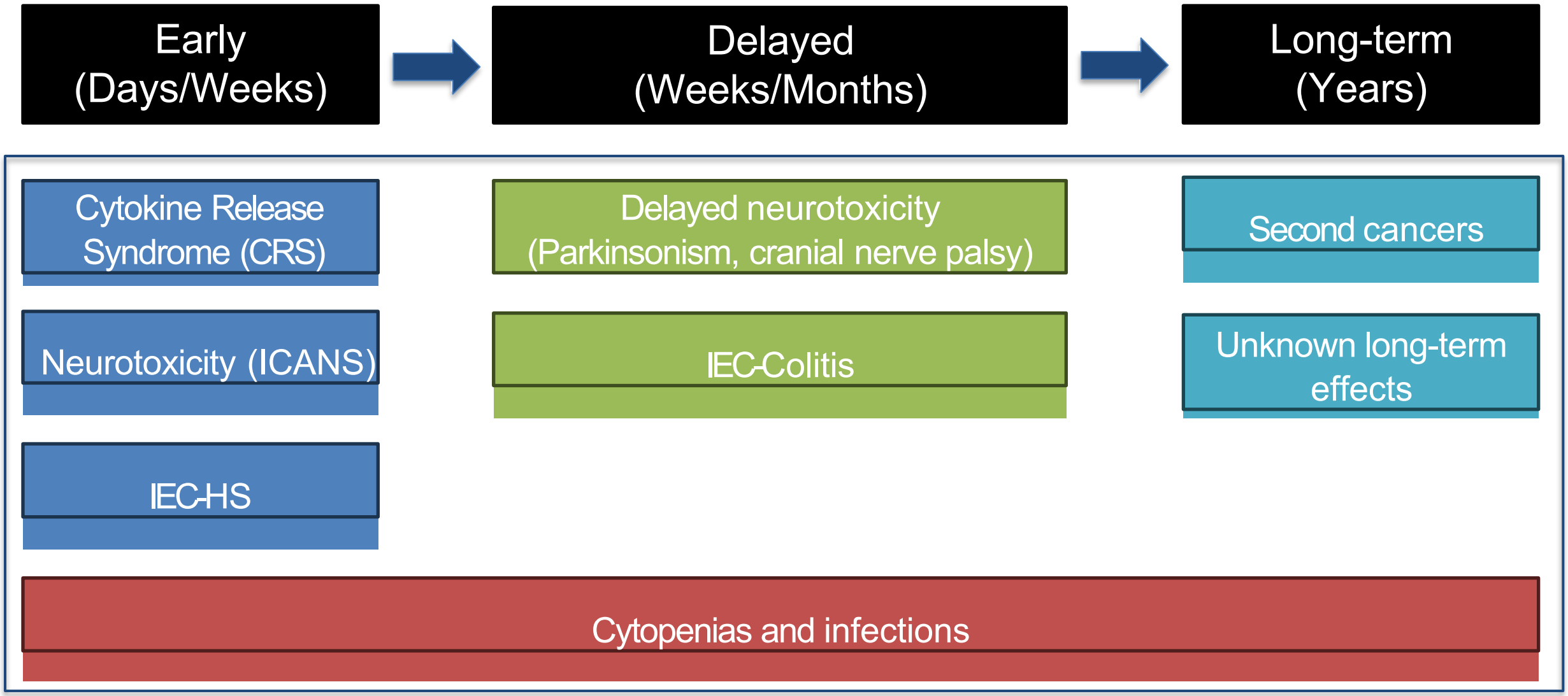
Surbhi Sidana*, Brett Reid*, Danai Dima*, Lauren C. Peres, Mahmoud Gaballa, Rahul Banerjee, Oren Pasvolsky, Aimaz Afrough, Christen Dillard, Christopher Ferreri, Shebli Atrash, Cindy Varga, Andrew Portuguese, Masooma Rana, Hitomi Hosoya, Lekha Mikkilineni, Vanna Hovanky, Saurabh Zanwar, Nilesh Kalariya, Damian Mikulski, Charlotte Wagner, Christopher R. Cahoon, Omar Castaneda Puglianini, Gabe De Avila, Christian Gordillo, Eli Zolotov, Jenny Bhurtel, Ariel Grajales-Cruz, Utkarsh Goel, Aishwarya Sannareddy, Jeries Kort, Rafaella Cassano, Shonali Midha, James Davis, Rebecca Gonzalez, Megan Herr, Zhuoer Xie, Hamza Hassan, Sneha Purvey, Marcus Geer, Kimberly Green, Fabiana Perna, Hien Liu, Taiga Nishihori, Jack Khouri, Shahzad Raza, Faiz Anwer, Susan Bal, Omar Nadeem, Ciara L. Freeman, Leyla Shune, Ran Reshef, Kenneth Shain, Melissa Alsina, Rachid Baz, Doug Sborov, Saurabh Dahiya, Frederick L. Locke, David Miklos, Peter Voorhees, Larry Anderson, Luciano Costa, Noa Biran, Shaji Kumar, Yi Lin*, Krina K. Patel* , Doris Hansen*

* contributed equally

Stanford MEDICINE

ASH 2025, Abstract #1034

Toxicities with Cilta-cel



Study Design

Population

- Patients with relapsed MM receiving standard of care cilta-cel
- Sites: 15 U.S centers
- **N=761** (May 2022 to December 2024)

Definitions

- **Delayed neurotoxicity (DNT) or Non-ICANS neurotoxicity (NINT):** Neurotoxicity events except ICANS including Parkinsonism, cranial nerve palsy, neuropathy, etc
- **NRM** was defined as death due any cause except myeloma progression

Analysis

- Risk factors for Parkinsonism and NRM were evaluated by univariable and multivariable analysis.
- Any NRM events occurring after disease progression were censored for analysis, except second primary malignancies

Sidana et al. ASH 2025, Abstract #1034

Summary

- Non-response to bridging therapy was associated with 10x risk of Parkinsonism and a higher NRM with cilta-cel
- **Effective tumor debulking with bridging is critical to decrease the risk of Parkinsonism and NRM with cilta-cel**
- Peak ALC was significantly higher in patients who developed Parkinsonism, with peak ≥ 3000/uL associated with 12% risk of Parkinsonism.
- Peak ALC ≥ 3000/uL can serve as a biomarker to identify patients for preemptive interventions and risk mitigation measures

100

Safety and Efficacy of Elranatamab in Combination With Iberdomide in Patients With Relapsed or Refractory Multiple Myeloma: Results from the Phase 1b MagnetisMM-30 Trial

Attaya Suvannasankha,[1] Jonathan L. Kaufman,[2] Ashraf Badros,[3] Michel Pavic,[4] Hock-Choong Lai,[5] Muhammad S Raza,[6] Parth S Shah,[7] Patrick Y. Muller,[8] Jorge Acosta,[8] Margaret Hoyle,[9] Erik R Vandendries,[10] Jay Cheng,[11] Alexander Lesokhin[12]

[1]Melvin and Bren Simon Comprehensive Cancer Center, Indiana University, Indianapolis, IN, USA; [2]Winship Cancer Institute, Emory University, Atlanta, GA, USA; [3]Greenebaum Comprehensive Cancer Center, University of Maryland, Baltimore, MD, USA; [4]Centre Intégré Universitaire de Santé et de Services Sociaux de l'Estrie - Centre Hospitalier Universitaire de Sherbrooke, Quebec, QC, Canada; [5]Icon Cancer Centre Townsville, Queensland, AU; [6]Dr. Everett Chalmers Hospital, Halifax, NS, Canada; [7]Dartmouth Hitchcock Medical Center, Hanover, NH, USA; [8]Bristol Myers Squibb, Boudry, Switzerland; [9]Pfizer Inc, Milan, Italy; [10]Pfizer Inc, Cambridge, MA, USA; [11]Pfizer Inc, Bothell, WA, USA; [12]Memorial Sloan Kettering Cancer Center, New York, NY, USA

Presented at the 67th ASH Annual Meeting and Exposition | December 6-9, 2025 | Orlando, FL

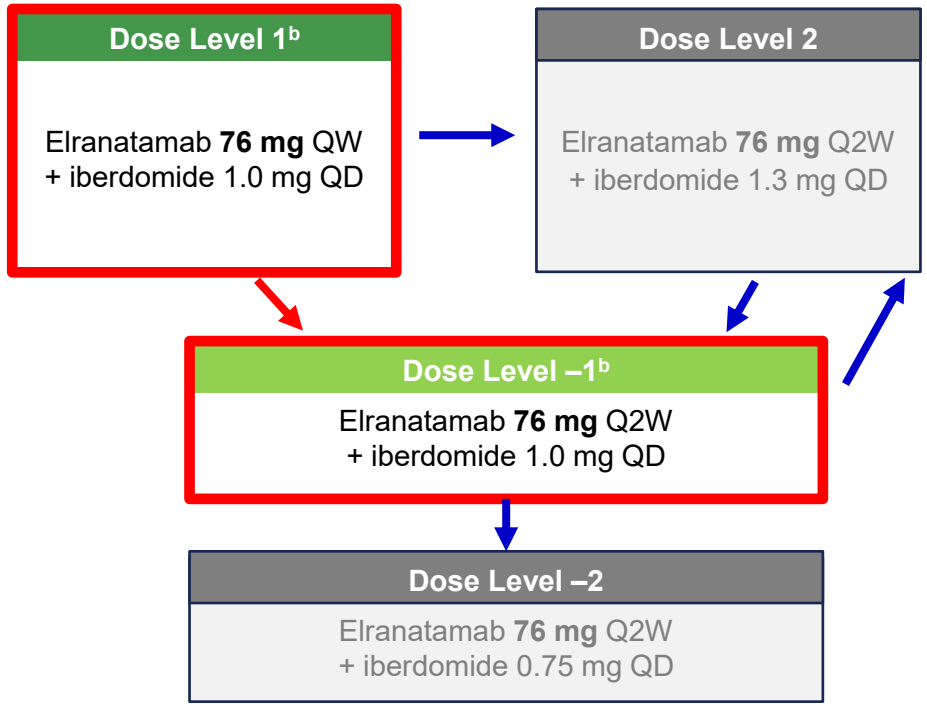
MagnetisMM-30 Study Design

- MagnetisMM-30 (NCT06215118) is a phase 1b, open-label, multicenter, prospective study
- **Part 1** (dose escalation) primary objective was to assess the tolerability and safety of elranatamab in combination with iberdomide to determine the recommended doses of the combination for evaluation in **Part 2** (randomized dose optimization)
  - A BOIN approach was used to guide dose escalation/de-escalation in **Part 1**

Patients with RRMM

Key inclusion criteria
- Age ≥18 years with MM per IMWG criteria
- ECOG PS 0-1
- 2-4 prior LOTs, including ≥1 IMiD and ≥1 PI[a]
- Relapsed or refractory to last LOT

Key exclusion criterion
- Stem cell transplant ≤12 weeks prior to enrollment or active GVHD
- Ongoing grade ≥2 peripheral sensory or motor neuropathy; history of grade ≥3 peripheral motor polyneuropathy



Primary endpoint
- DLTs during DLT observation period

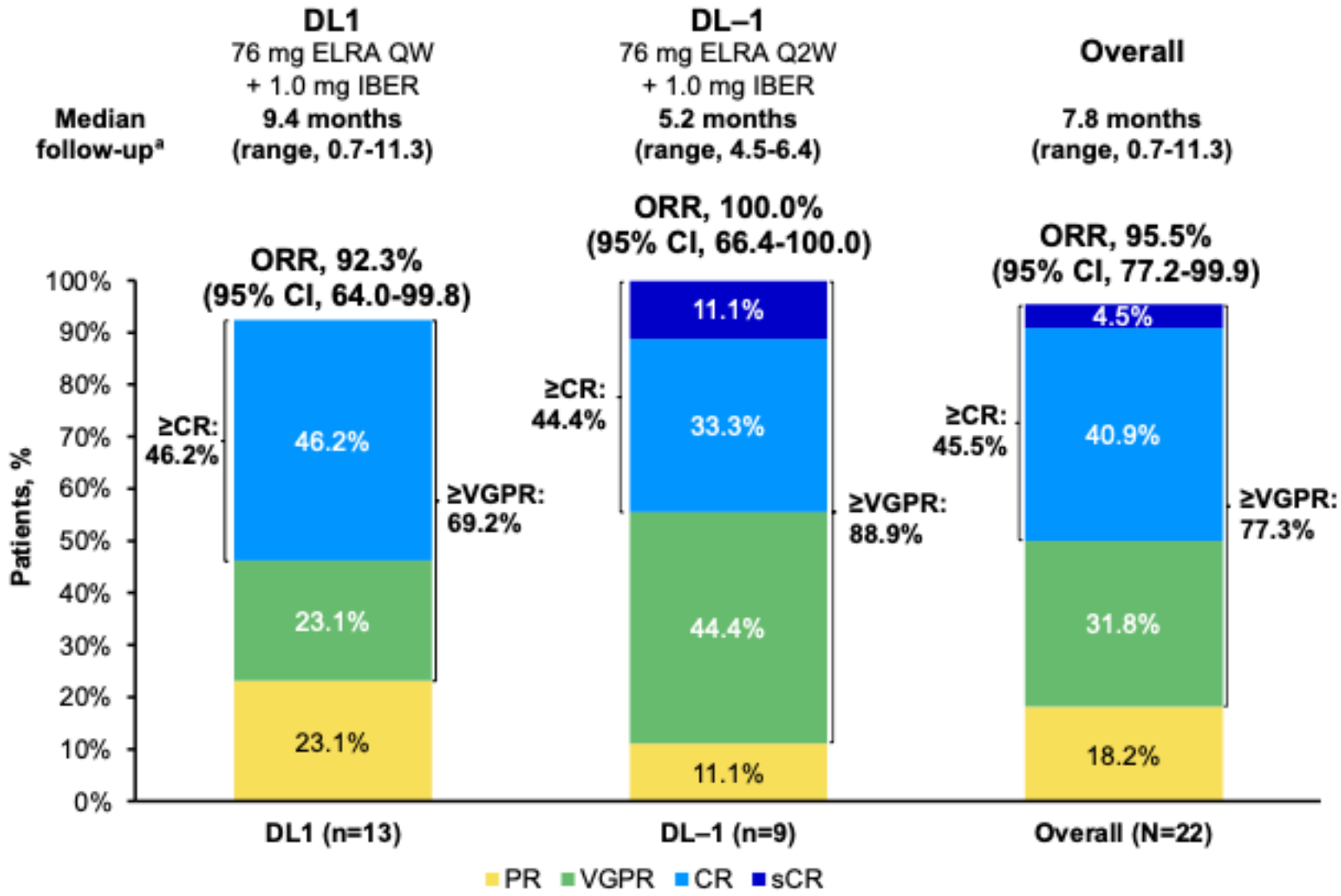
Secondary endpoints
- AEs and laboratory abnormalities
- ORR[c]
- CR rate[c]
- Time-to-event endpoints[c]
- PK
- MRD negativity rate[c]
- Immunogenicity

[a] All patients must have received ≥2 consecutive cycles of an IMiD-containing regimen and ≥2 consecutive cycles of a PI or PI-containing regimen; [b] All patients received an initial 14-day cycle of elranatamab (12 mg on day 1, 32 mg on day 4, 76 mg on day 8) without iberdomide. Iberdomide was dosed at 21 out of 28 days for subsequent cycles; [c] Per IMWG criteria

AE=adverse event; BOIN=Bayesian Optimal Interval Design; CR rate=complete response rate; DLT=dose-limiting toxicity; ECOG PS=Eastern Cooperative Oncology Group performance status; GVHD=graft vs host disease; IMiD=immunomodulatory drug; IMWG=International Myeloma Working Group; LOT=line of therapy; MM=multiple myeloma; MRD=minimal residual disease; ORR=objective response rate; PI=proteasome inhibitor; PK=pharmacokinetics; QD=once daily; QW=once weekly; Q2W=once every 2 weeks

ORR

- Overall, the confirmed ORR by investigator was 95.5% (95% CI, 77.2-99.9)
- Responses occurred early
  - Median time to response was 1.4 months (range, 0.5-2.7)



[a] Simple median of observation times.
CR=complete response; DL=dose level; ELRA=elranatamab; IBER=iberdomide; ORR=objective response rate; PR=partial response; sCR=stringent complete response; VGPR=very good partial response

Redefining Functional High-Risk (FHR) Multiple Myeloma (MM) in the Context of Upfront Quadruplet (QUAD) Therapy and Autologous Stem Cell Transplantation (ASCT)

Luciano Costa[1], Susan Bal[1], Kelly Godby[1], Gayathri Ravi[1], Eva Medvedova[2], Natalie Callander[3], Rebecca Silbermann[2], Bhagi Dholaria[4], Forest Huls[5], Baylie Mullinax[1], Laura Joiner[1], Caitlin Hagedorn[1], Binod Dhakal[6].

1 University of Alabama at Birmingham, Division of Hematology and Oncology, Birmingham, AL; 2 Oregon Health Sciences University, Portland, OR; 3 University of Wisconsin, Madison, WI, United States; 4 Vanderbilt University, Nashville, TN; 5 University of Alabama at Birmingham, Department of *Pathology, Birmingham, AL; 6 Medical College of Wisconsin, Milwaukee, WI.*

coMMit
Myeloma Trials, Innovated

O'NEAL COMPREHENSIVE CANCER CENTER
UAB THE UNIVERSITY OF ALABAMA AT BIRMINGHAM

Conclusions

In NDMM treated with QUAD + ASCT :

FHR36 identifies a population with expected OS ~24 months= **New Definition**

FHR36 is associated with worse response, 2PFS and OS in patients with progression after QUAD + ASCT

TCRT in 2nd line is associated with improved 2PFS in patients with progression after QUAD + ASCT

coMMit
Myeloma Trials, Innovated

Brief Takeaways on Early Relapse

1. The combination of Teclistamab and Daratumumab in early relapse is remarkable and will likely be available soon - but infectious concerns must be mitigated

2. Long term outcomes with cilta-cel in standard risk are excellent with 30-month PFS 80% in early line and 60% in late line

3. Key toxicities with cilta-cel can be mitigated with bridging therapy and ALC monitoring

4. Combining Elranatamab and Iberdomide is both feasible and effective

5. The definition of Functional High Risk could reset to 36 months due to better outcomes in frontline therapy

Late Relapse

1. *in vivo* CAR T (LBA-1)
2. Anito-cel in relapsed MM (#256)
3. AZD0120 CAR T (#269)
4. Teclistamab-Talquetamab in EMD (#698)
5. Etentamig plus pomalidomide (#247)

LBA-1

MRD-negative outcomes following a novel, *in vivo* gene therapy generating anti-BCMA CAR-T cells in patients with RRMM: Preliminary results from inMMyCAR, the first-in-human Phase 1 study of KLN-1010

Simon Harrison[1], P. Joy Ho[2], Sueh-Ii Lim[3], Stephanie Talam[2], Hannah Pahl[1], Dharmesh Dingar[4], Scott Currence[4], Travis Quigley[4], Andrew Spencer[3]

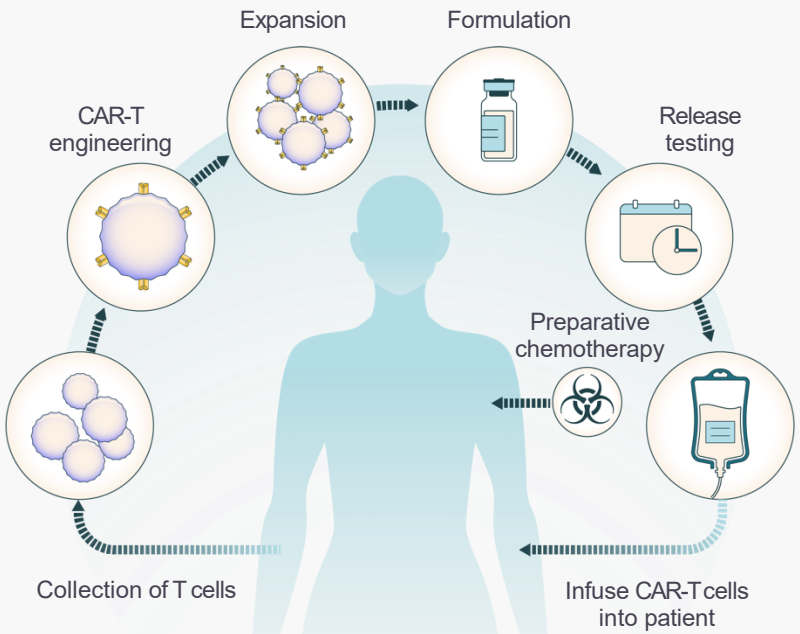
[1]Peter MacCallum Cancer Centre, Melbourne, Victoria, Australia; [2]Royal Prince Alfred Hospital, Sydney, New South Wales, Australia; [3]The Alfred Hospital, Melbourne, Victoria, Australia; [4]Kelonia Therapeutics, Inc., Boston, Massachusetts, United States.

kelonia inMMyCAR

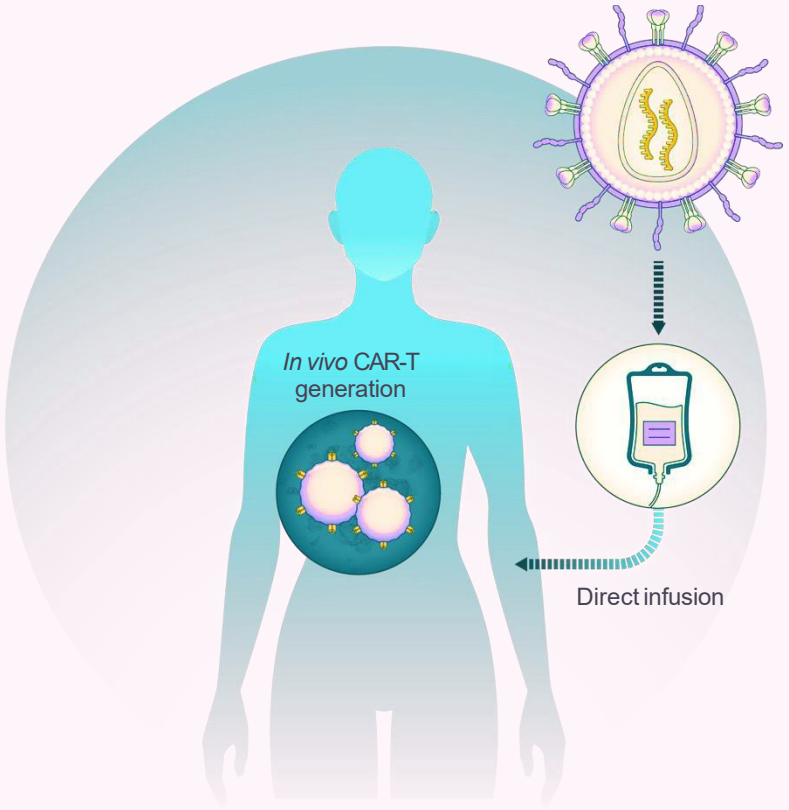
Presented at the 67th ASH Annual Meeting and Exposition; December 6-9, 2025; Orlando, FL, USA.

Expanding the reach of CAR-T cells with *in vivo* gene delivery[1,2]

Ex vivo CAR T



In vivo CAR T with KLN-1010 lentiviral particles



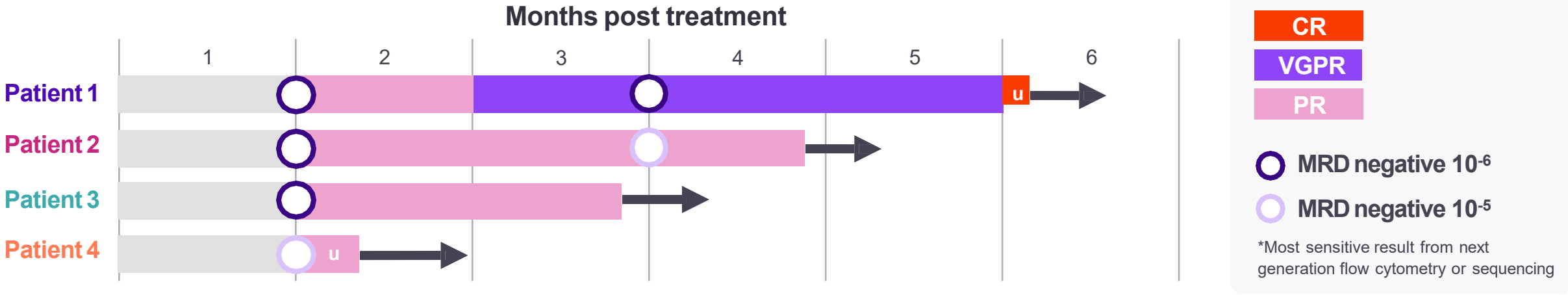
- Eliminates preconditioning lymphodepletion
- Greatly simplified logistics to expand access
- No *ex vivo* culture may increase T-cell fitness
- Reduced cost of goods and manufacturing

CAR, chimeric antigen receptor.

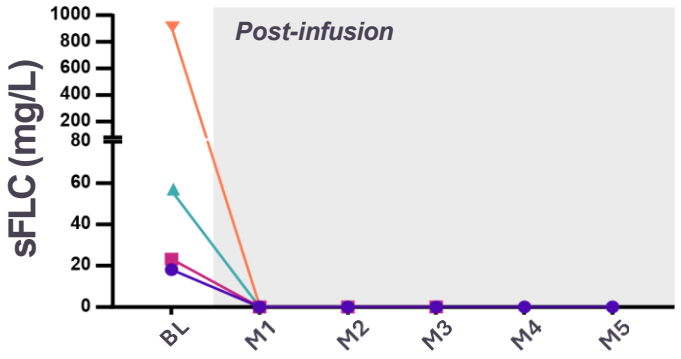
1. Bot A et al. *Nat Rev Drug Discov*. 2025 Sep 30. doi: 10.1038/s41573-025-01291-5; **2.** Najibi AJ. T cell-specific *in vivo* transduction with preclinical candidate KLN-1010 generates BCMA-directed CAR-T cells with potent anti-multiple myeloma activity (abstract #48). Poster presented at: AACR Annual Meeting; April 5-10, 2024.

kelonia inMMyCAR

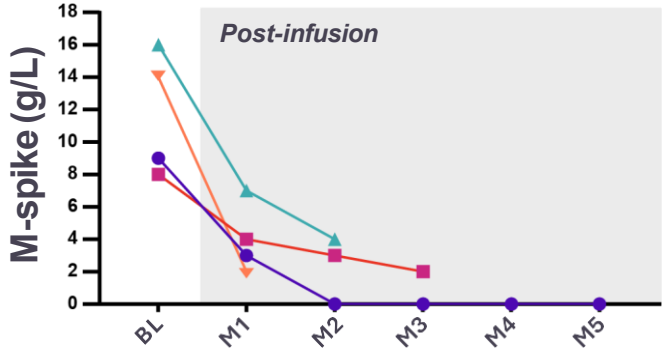
Deep, ongoing MRD-negative responses were observed across first 4 patients



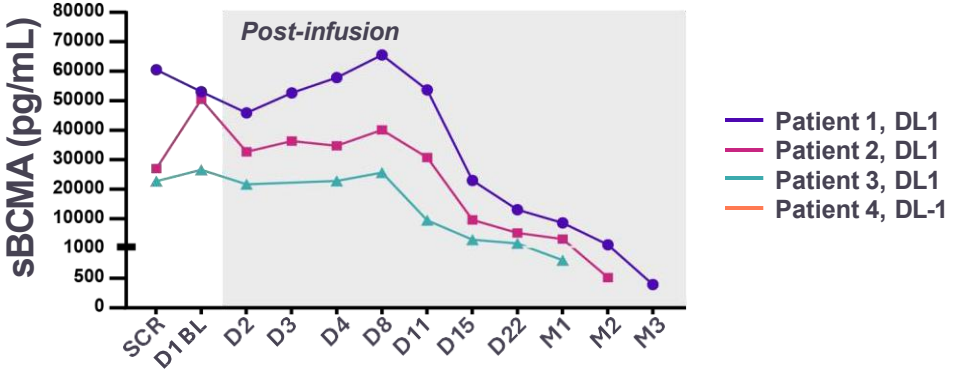
Involved sFLC



M-spike levels



Soluble BCMA



BCMA, B-cell maturation antigen; BL, baseline; CR, complete response; D, study day; M, study month; M-spike, monoclonal protein spike; MRD, minimal residual disease; PR, partial response; SCR, screening; sFLC, serum free light chain; u, unconfirmed response; VGPR, very good partial response.

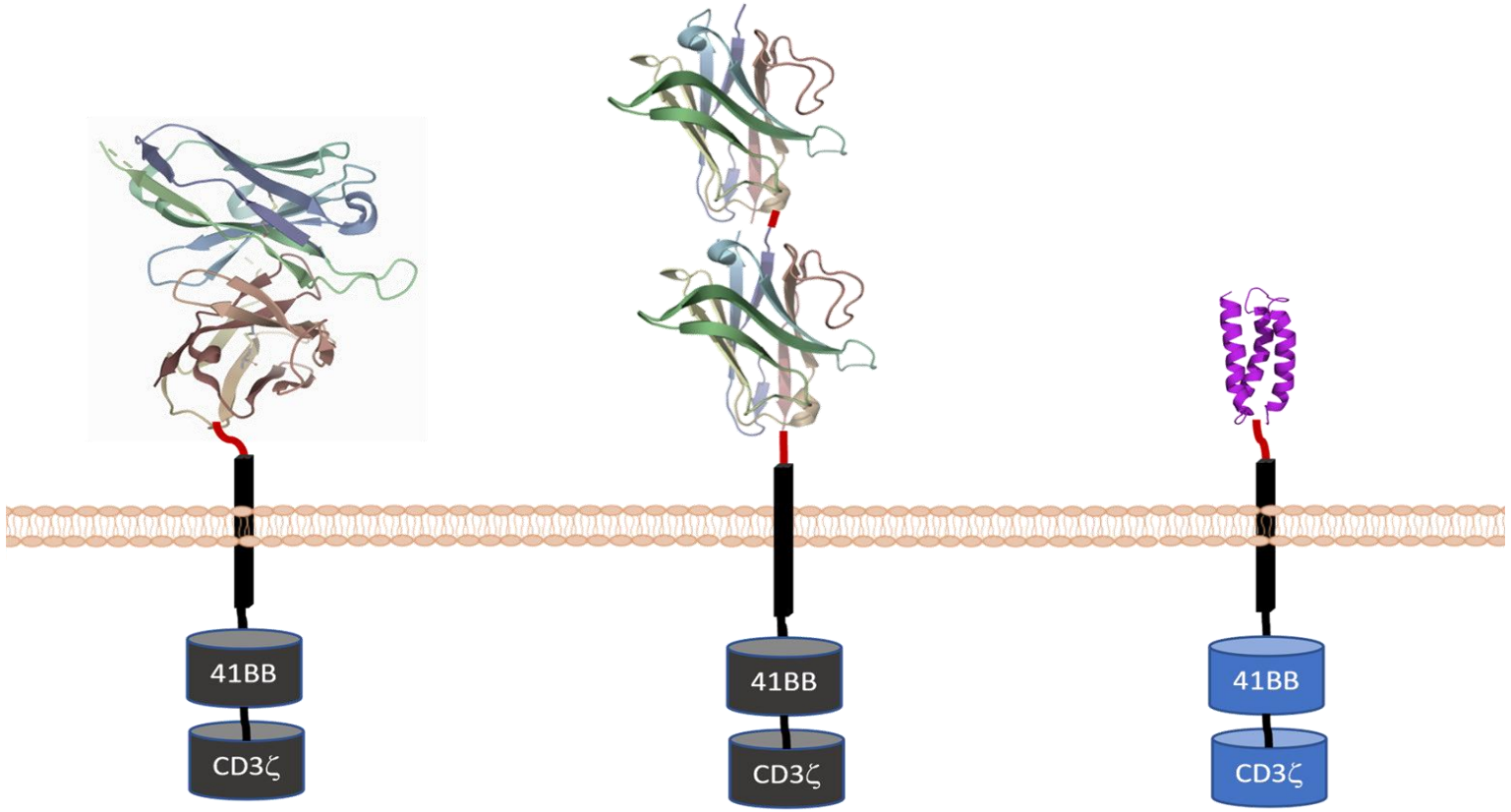
kelonia inMMyCAR

Abstract 256
Phase 2 Registrational Study of Anitocabtagene Autoleucel for the Treatment of Patients with Relapsed and/or Refractory Multiple Myeloma (RRMM): Updated Results from iMMagine-1

Krina Patel, MD, MSc; Binod Dhakal, MD; Gurbakhash Kaur, MD; Richard T. Maziarz, MD; Natalie S. Callander, MD; Adam S. Sperling, MD, PhD; Carolina Schinke, MD; Andrzej J. Jakubowiak, MD, PhD; Noa Biran, MD; Douglas W. Sborov, MD, MS; Cindy Varga, MD; Larry D. Anderson, Jr., MD, PhD; Abhinav Deol, MD; Abraham S. Kanate, MD; Mehmet Hakan Kocoglu, MD; Melhem Solh, MD; Kamalika C. Banerjee, MS, MA; Krishna Rana, PharmD; Ana Kostic, MD; Enrique Granados, MD; Carolyn C. Jackson, MD, MPH; Christopher R. Heery, MD; Tim Welliver, MD, PhD; Ciara L. Freeman, MD, PhD**;** and Matthew J. Frigault, MD, MS

Anitocabtagene autoleucel (anito-cel/CART-ddBCMA)

Autologous BCMA-directed CAR T-cell therapy using a novel, D-Domain binder[1,2]



scFv
(~25 kDa)

Bivalent camelid VHH
(~30 kDa)

D-Domain
(~8 kDa)

D-Domain Attributes:
Non-Antibody Derived Synthetic Protein[1,2]

Size

Small D-Domain construct facilitates high transduction efficiency and CAR positivity[2-4] resulting in a low total cell dose

Structure & Stability

D-Domain CARs are stable and lack tonic signaling[4,6] due to the rapid folding, lack of disulfide bonds, and hydrophobic core[5,6] of the D-Domain

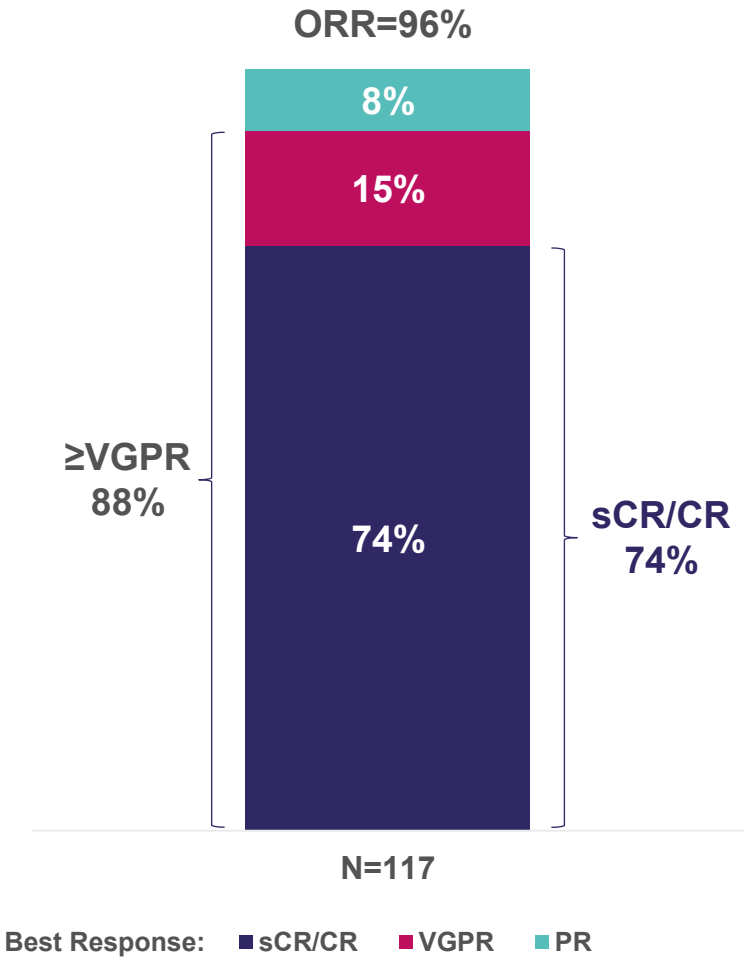
Binding

The D-Domain binder has a fast off-rate[4] and high CAR surface expression[4]. This combination may allow optimal tumor cell killing without prolonged inflammation

[1]Rotte, et al. Immuno-Oncology Insights 2022; 3(1), 13–24; [2]Frigault, et al. Blood Adv. 2023; 7(5):768-777; [3]Cante-Barrett, et al. BMC Res. Notes 2016; 9:13; [4]Buonato, et al. Mol. Cancer Ther. 2022; 21(7):1171-1183; [5]Zhu, et al. Proc. Nat. Acad. Sci. 2003; 100(26): 15486-15491; [6]Qin, et al. Mol. Ther. 2019; 27(7): 1262-1274.

iMMagine-1: Overall Response Rate and Depth of Response

Efficacy Evaluable Patients, N=117



- Responses continue to deepen over time
- At a median follow-up of 15.9 months, IRC-assessed ORR was 96% and sCR/CR rate was 74%

	Median (months)	Interquartile Range	Min, Max
Time to first response	1.0	1.0, 1.9	0.9, 13.8
Time to best response	4.8	2.1, 9.0	0.9, 23.8
Time to sCR/CR	3.2	2.0, 9.2	0.9, 23.8

Responses are per IMWG criteria and are IRC assessed; ORR defined as partial response or better.
CR, complete response; IRC, independent review committee; ORR, overall response rate; PR, partial response; sCR, stringent complete response; VGPR, very good partial response

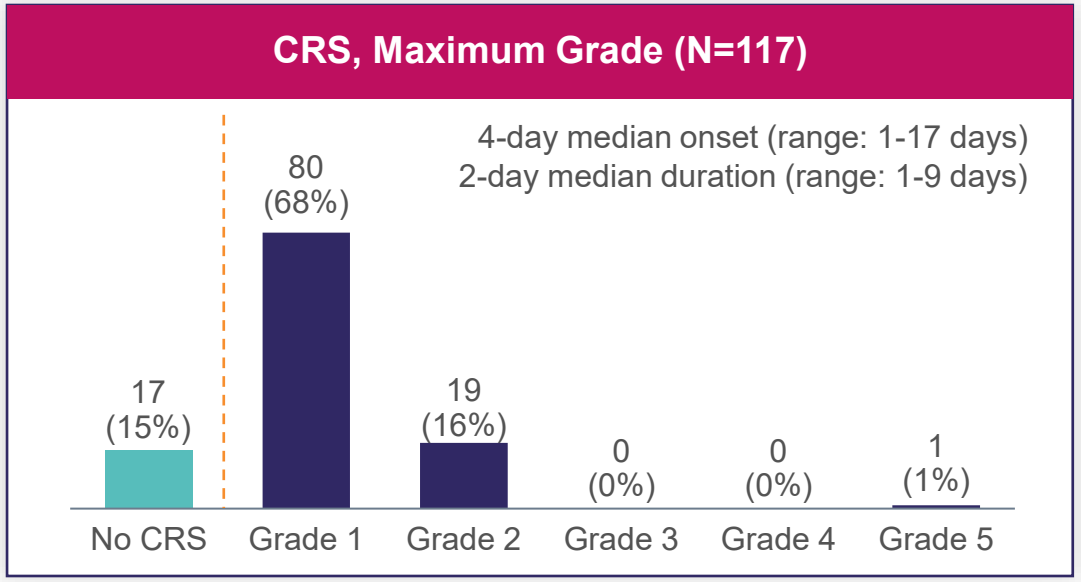
iMMagine-1: PFS and OS Rates Estimated by Kaplan-Meier

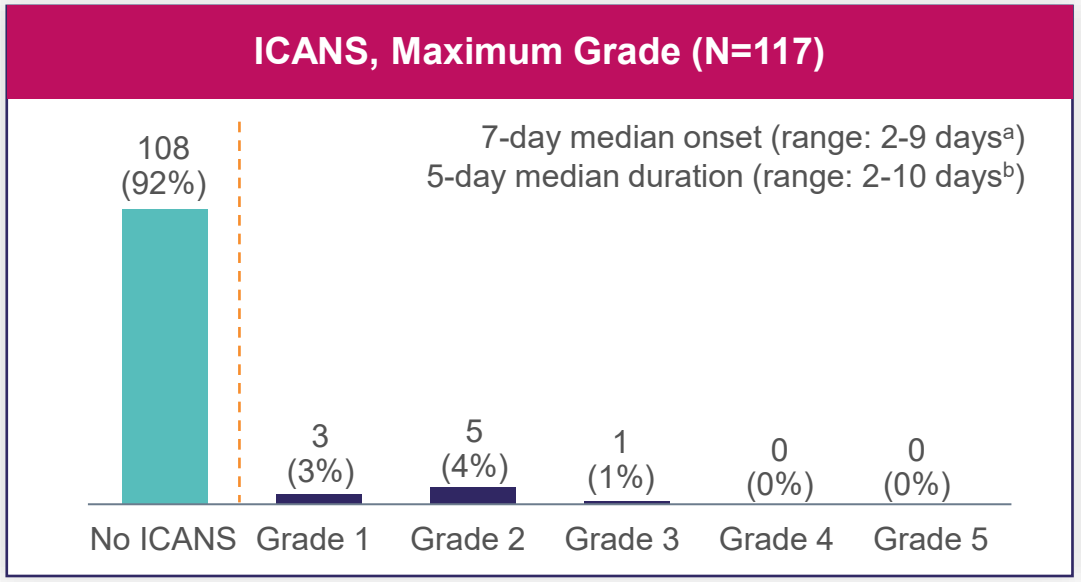
Median PFS and OS were not reached

N=117	PFS Rate (%) (95% CI)	OS Rate (%) (95% CI)
6-Month	93.1 (86.7, 96.5)	95.7 (90.0, 98.2)
12-Month	82.1 (73.6, 88.1)	94.0 (87.8, 97.1)
18-Month	67.4 (55.4, 76.8)	88.0 (78.8, 93.4)
24-Month	61.7 (48.0, 72.8)	83.0 (70.7, 90.5)

Median follow-up of 15.9 months (range: 0.3 – 33.1 months)
PFS, progression-free survival; OS, overall survival

iMMagine-1: Safety Update





- 95% (111/117) of patients had either no CRS or CRS that resolved by ≤10 days of anito-cel infusion
- No new treatment-related or treatment-emergent deaths have occurred since the previous May 1, 2025 datacut
- No secondary primary malignancies of T-cell origin have occurred
- No replication competent lentivirus detected

No delayed or non-ICANS neurotoxicities, including no Parkinsonism, no cranial nerve palsies, and no Guillain-Barré syndrome, and no immune effector cell-associated enterocolitis have been observed to date at ≥10 months since anito-cel infusion

[a]With the exception of n=1 Grade 1 ICANS (confusion) on day 31 post infusion that rapidly resolved. [b]With the exception of n=1 max Grade 2 ICANS with 29-day duration to resolution
Note: Updates to data resulting from ongoing data review; CRS and ICANS assessed per American Society for Transplantation and Cellular Therapy criteria
CRS, cytokine release syndrome; ICANS, immune-effector cell-associated neurotoxicity syndrome

P269

Safety and Efficacy of AZD0120, a BCMA/CD19 Dual-Targeting CAR T-cell Therapy, in Relapsed/Refractory Multiple Myeloma: Preliminary Results From the DURGA-1 Phase 1b/2 Study

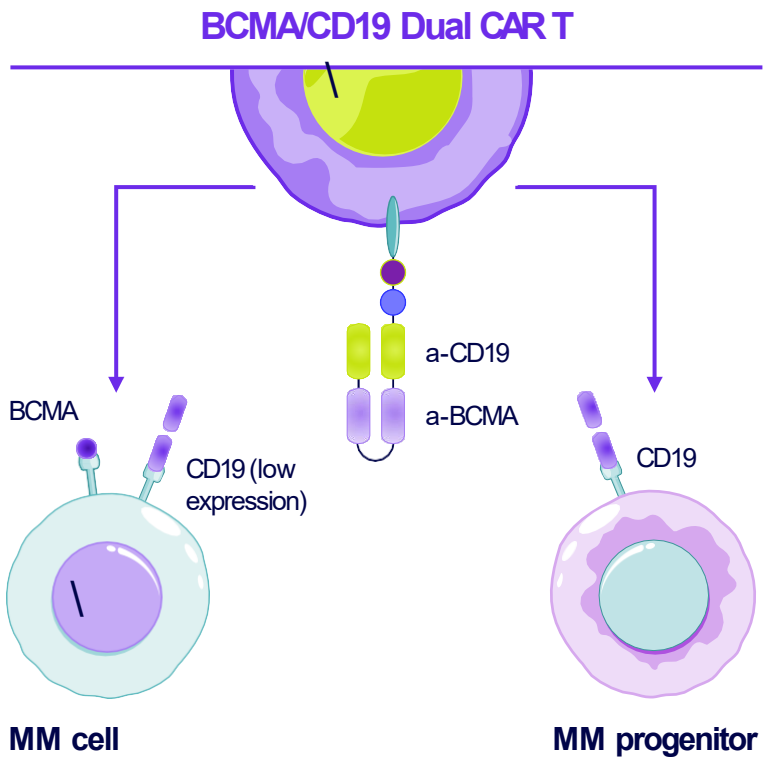
Shambavi Richard, MD[1], Mahmoud Gaballa, MMBCh[2], Tara Gregory, MD[3], Saurabh Chhabra, MD, MS[4], Larry D. Anderson Jr, MD, PhD[5], Luciano J. Costa, MD, PhD[6], Caitlin Costello, MD[7], Scott R. Goldsmith, MD[8], Doris K. Hansen, MD[9], Sridevi Rajeeve, MD[10], Shaji Kumar, MD[11], Aravind Ramakrishnan, MD[12], Minoo Battiwalla, MD, MS[13], Ajay K. Nooka, MD, MPH[14], Hira Shaikh, MBBS[15], Meiyue G. Hong, MD[16], Steven Wang, MS[17], Patricia Cheung, PhD[18], Liang Li, PhD[19], Binod Dhakal, MD[20]

[1]Icahn School of Medicine at Mount Sinai, New York, NY; [2]The University of Texas MD Anderson Cancer Center, Houston, TX; [3]Colorado Blood Cancer Institute, Denver, CO; [4]Mayo Clinic Arizona, Phoenix, AZ; [5]Hematologic Malignancies and Cellular Therapy Program, Simmons Comprehensive Cancer Center, UT Southwestern Medical Center, Dallas, TX; [6]University of Alabama at Birmingham, Birmingham, AL; [7]University of California San Diego Moores Cancer Center, San Diego, CA; [8]City of Hope Comprehensive Cancer Center, Duarte, CA; [9]Moffitt Cancer Center, Tampa, FL; [10]Memorial Sloan Kettering Cancer Center, New York, NY; [11]Mayo Clinic, Rochester, MN; [12]Sarah Cannon Transplant and Cellular Therapy, St. David's South Austin Medical Center, Austin, TX; [13]Sarah Cannon Transplant and Cell Therapy Network, Nashville, TN; [14]Winship Cancer Institute of Emory University, Atlanta, GA; [15]University of Iowa Hospital & Clinic, Iowa City, IA; [16]AstraZeneca, Boston, MA; [17]AstraZeneca, Mississauga, Canada; [18]AstraZeneca, South San Francisco, CA; [19]AstraZeneca, Gaithersburg, MD; [20]Medical College of Wisconsin, Milwaukee, WI

Presented at the 67th American Society of Hematology (ASH) Annual Meeting; December 6–9, 2025; Orlando, Florida

AZD0120: A Novel BCMA/CD19 Dual CAR T

Dual Target



Next-Generation Manufacturing

Faster to Patients

Manufactured in
<3 days

Better T Cells

Younger, fitter naive T cells

Safety profile enabling outpatient administration and monitoring

Making cell therapy available to more patients

AZD0120 was formerly named GC012F, and next-generation manufacturing refers to the FasTCAR platform.
BCMA, B-cell maturation antigen; CAR T, chimeric antigen receptor T-cell therapy; MM, multiple myeloma.

CRS and ICANS

CRS	DL1 (n=12)	DL2 (n=14)	Total (n=26)
CRS, overall	**9 (75%)**	**7 (50%)**	**16 (62%)**
Grade 1	9 (75%)	6 (43%)	15 (58%)
Grade 2	0	1 (7%)	1 (4%)
Grade 3+	0	0	0
Onset time, median (range), days	9 (2–11)	9 (8–10)	9 (2–11)*
Duration, median (range), days	1 (1–4)	2 (1–2)	1.5 (1–4)
CRS management			
Tocilizumab	7 (58%)	5 (36%)	12 (46%)
Dexamethasone	1 (8%)	2 (14%)	3 (12%)
Anakinra	0	1 (7%)	1 (4%)

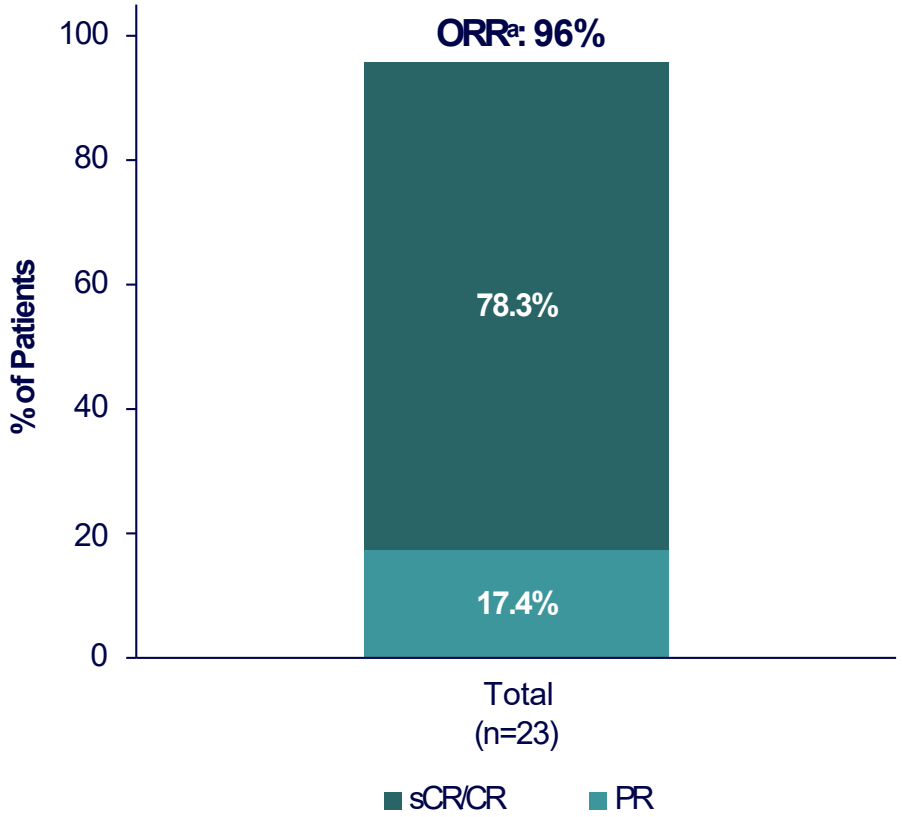
- **No grade 3+ CRS reported**
- ***CRS onset on day 8–11 for 15 of 16 patients**

ICANS	DL1 (n=12)	DL2 (n=14)
ICANS, overall	**0**	**1 (7%)**
Grade 1	0	1 (7%)
Grade 2	0	0
Grade 3+	0	0
Onset time, days	NA	10
Duration, day	NA	1

- **No delayed neurotoxicities, including no Parkinsonism, no cranial nerve palsies, and no Guillain-Barré syndrome reported**
- **No IEC-associated colitis reported**
- **Only one grade 1 ICANS event**
- **One patient with IEC-HS (DL1, grade 2); resolved within 7 days**

CRS, cytokine release syndrome; DL, dose level; IEC, immune effector cell; IEC-HS, immune effector cell–associated hemophagocytic lymphohistiocytosis-like syndrome; ICANS, immune effector cell–associated neurotoxicity syndrome; NA, not applicable.

Efficacy: 96% ORR, 78% CR



- **Median follow-up time = 3.9 months**
- **Median time to first response = 28 days**
- **Responses deepened over time**

	Total (n=23)	BCMA CAR T Exposed (n=5)
ORR	96%	100%
sCR/CR	78%	80%
Follow-up, median (range), months	3.9 (0.9–19.7)	3.9 (3.0–4.0)

Efficacy-evaluable population defined as all patients who received conformed AZD0120 infusion at the targeted DL with measurable disease at baseline and at least one post-baseline efficacy assessment.
[a]Response as assessed by study investigator using IMWG criteria.
BCMA, B-cell maturation antigen; CAR T, chimeric antigen receptor T-cell therapy; CR, complete response; DL, dose level; IMWG, International Myeloma Working Group; ORR, objective response rate; PR, partial response; sCR, stringent complete response.

Efficacy and Safety of Talquetamab + Teclistamab in Patients With Relapsed/Refractory Multiple Myeloma and Extramedullary Disease: Updated Phase 2 Results From the RedirecTT-1 Study With Extended Follow-Up

Saad Z Usmani[1]*, Shaji Kumar[2]*, María-Victoria Mateos[3], Jing Christine Ye[4], Shebli Atrash[5], Hila Magen[6], Hang Quach[7], Michael P Chu[8], Suzanne Trudel[9], Joshua Richter[10], Paula Rodríguez-Otero[11], Hun Chuah[12], Moshe Gatt[13], Eva Medvedova[14], Shahzad Raza[15], Dok Hyun Yoon[16], Tadao Ishida[17], Jeffrey V Matous[18], Laura Rosiñol[19], Koichi Onodera[20], Carmela Maffucci[21], Emma Scott[22], Christoph Heuck[22], Jenny Zhang[22], Todd Henninger[21], Lisa O'Rourke[22], Payal Thakkar[21], Mariacristina Festa[23], Guoqiang Zhang[22], Sheetal Khedkar[24], Lin Huang[22], Jiangxiu Zhou[22], Mikihiro Takamoto[25], Lixia Pei[21], Jiashen Lu[26], Nicholas Au[22], Maria Krevvata[22], Yael C Cohen[27]

[1]Memorial Sloan Kettering Cancer Center, New York, NY, USA; [2]Mayo Clinic Rochester, Rochester, MN, USA; [3]University Hospital of Salamanca/IBSAL/CIC/CIBERONC, Salamanca, Spain; [4]MD Anderson Cancer Center, University of Texas, Houston, TX, USA; [5]Levine Cancer Institute-Atrium Health, Charlotte, NC, USA; [6]Chaim Sheba Medical Center, Ramat-Gan, Faculty of Medical and Health Sciences, Tel Aviv University, Tel Aviv, Israel; [7]University of Melbourne, St Vincent's Hospital, Melbourne, VIC, Australia; [8]Alberta Health Services, Edmonton, AB, Canada; [9]Princess Margaret Cancer Centre, Toronto, ON, Canada; [10]Mount Sinai Medical Center, New York, NY, USA; [11]Cancer Center Clínica Universidad de Navarra, Cima, Pamplona, Spain; [12]Royal Perth Hospital, Perth, WA, Australia; [13]Hadassah Medical Cener, Hebrew University of Jerusalem, Jerusalem, Israel; [14]Knight Cancer Institute, Oregon Health and Science University, Portland, OR, USA; [15]Taussig Cancer Institute, Cleveland Clinic, Cleveland, OH, USA; [16]Asan Medical Center, University of Ulsan College of Medicine, Seoul, Republic of Korea; [17]Japanese Red Cross Medical Center, Tokyo, Japan; [18]Colorado Blood Cancer Institute and Sarah Cannon Research Institute, Denver, CO, USA; [19]Hospital Clínic de Barcelona, IDIBAPS, Barcelona, Spain; [20]Tohoku University Hospital, Sendai shi, Miyagi, Japan; [21]Johnson & Johnson, Raritan, NJ, USA; [22]Johnson & Johnson, Spring House, PA, USA; [23]Johnson & Johnson, Leiden, Netherlands; [24]Johnson & Johnson, Horsham, PA, USA; [25]Johnson & Johnson, Tokyo, Japan; [26]Johnson & Johnson, Shanghai, China; [27]Tel Aviv Sourasky (Ichilov) Medical Center, Gray Faculty of Medical and Health Sciences, Tel Aviv University, Tel Aviv, Israel

*Contributed equally.

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RedirecTT-1 Phase 2 EMD (Tal + Tec): Largest Dedicated Study in Patients With True EMD

Screening

Eligibility criteria

- Triple-class exposed RRMM[a]
- True EMD, defined as ≥1 nonradiated bone-independent soft tissue plasmacytoma ≥2 cm in greatest dimension confirmed by central review of PET-CT scans[b,c]
- Prior CAR-T and non-BCMA/-GPRC5D bispecific antibody therapies were permitted
- Nonsecretory and oligosecretory disease were permitted

Treatment

Tal 0.8 mg/kg Q2W SC[d,e]
+
Tec 3.0 mg/kg Q2W SC[d,e]

Option to switch to monthly dosing after 4 cycles and ≥VGPR, or after 6 cycles (irrespective of response)

Step-up dosing[d] 2–4 days apart (Tal + Tec)

SUD1: 0.01 mg/kg + 0.06 mg/kg

SUD2: 0.06 mg/kg + 0.3 mg/kg

SUD3: 0.4 mg/kg + 1.5 mg/kg

Endpoints

Primary endpoint: ORR[f]

Secondary endpoints:

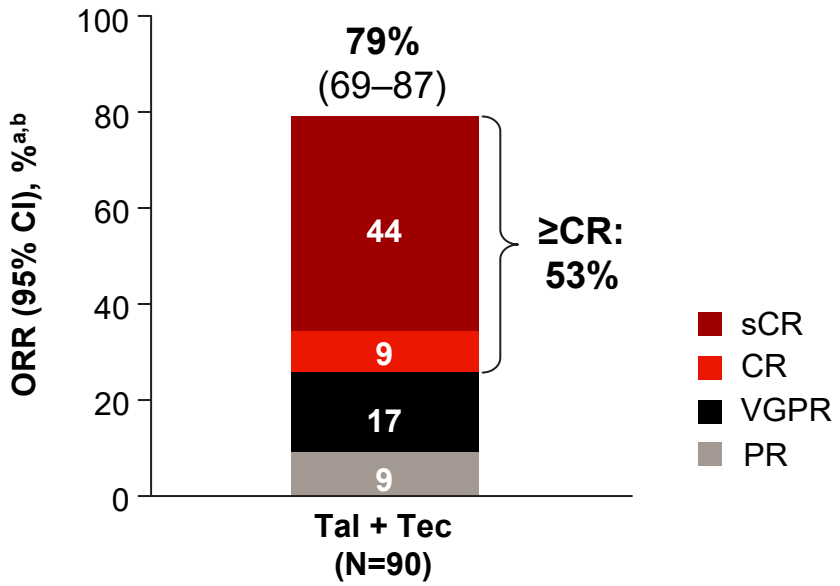
- DOR[f]
- PFS[f]
- OS
- Safety

[a]Includes prior exposure to a proteasome inhibitor, immunomodulatory drug, anti-CD38 monoclonal antibody. [b]Patients may have had paramedullary plasmacytomas in addition to true EMD. [c]Whole-body MRI permitted with sponsor approval. [d]Tal and Tec administered on the same day, 30 (±10) minutes apart, for all step-up and full treatment doses. [e]Until disease progression. [f]Response and PFS were assessed by an independent review committee per IMWG criteria; EMD response was assessed by PET-CT or MRI whole-body scans. CAR, chimeric antigen receptor; DOR, duration of response; MRI, magnetic resonance imaging; PET-CT, positron emission tomography–computed tomography; Q2W, every other week; SC, subcutaneous; SUD, step-up dose; VGPR, very good partial response.

Kumar S, et al. *N Engl J Med* 2025; doi:10.1056/NEJMoa2514752.

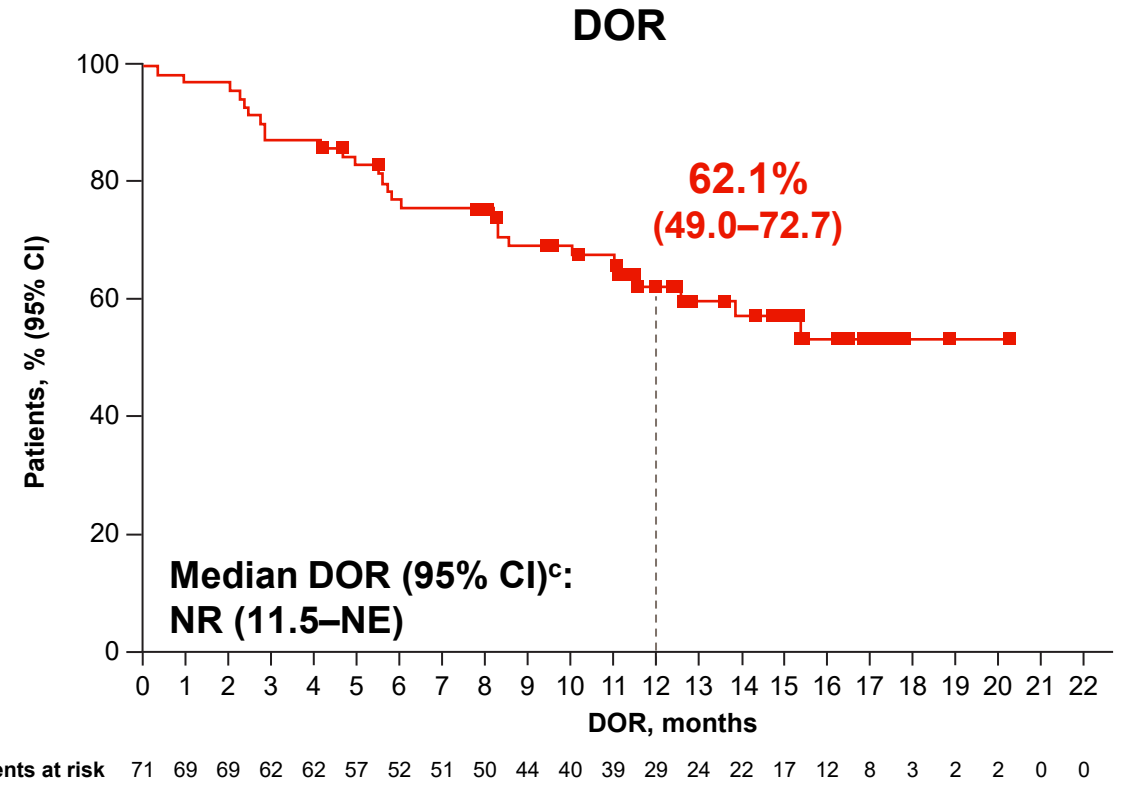
Presented by S Usmani at the 67th American Society of Hematology (ASH) Annual Meeting; December 6–9, 2025; Orlando, FL, USA

RedirecTT-1 Phase 2 EMD (Tal + Tec): Deep, Durable Responses at 16.8 Months Median Follow-up



Median (range) time to:

- First response, 2.6 (1.0–5.8) months
- Best response, 5.1 (1.0–16.6) months

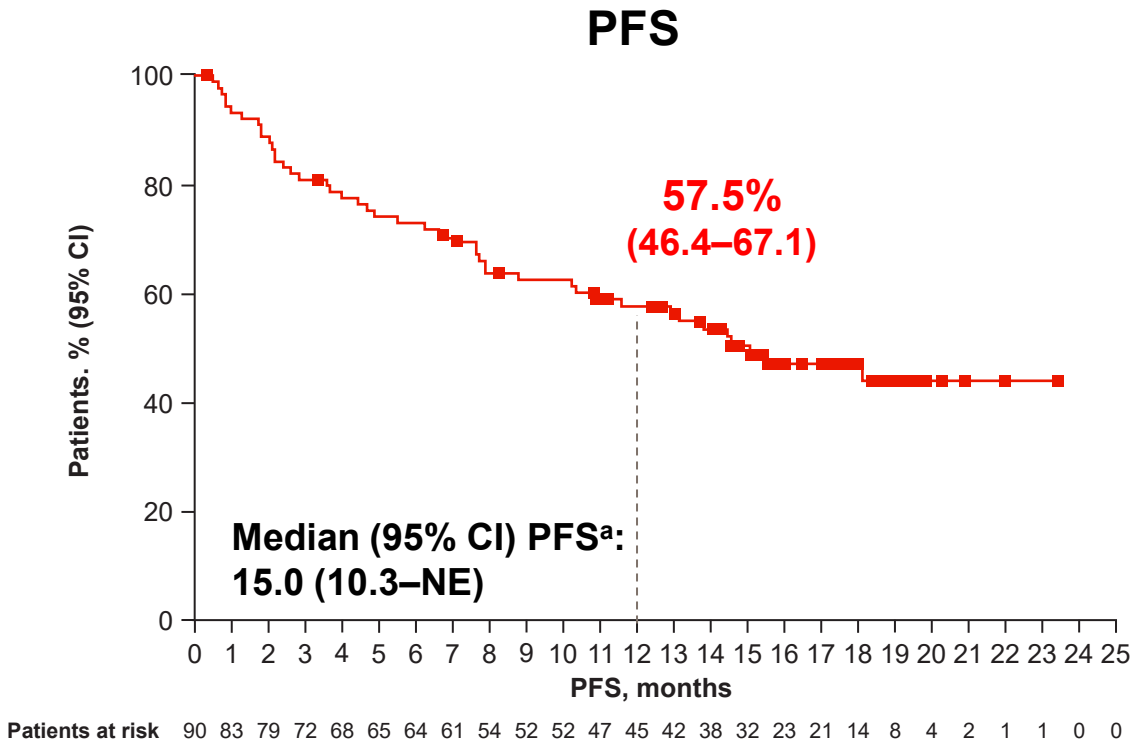


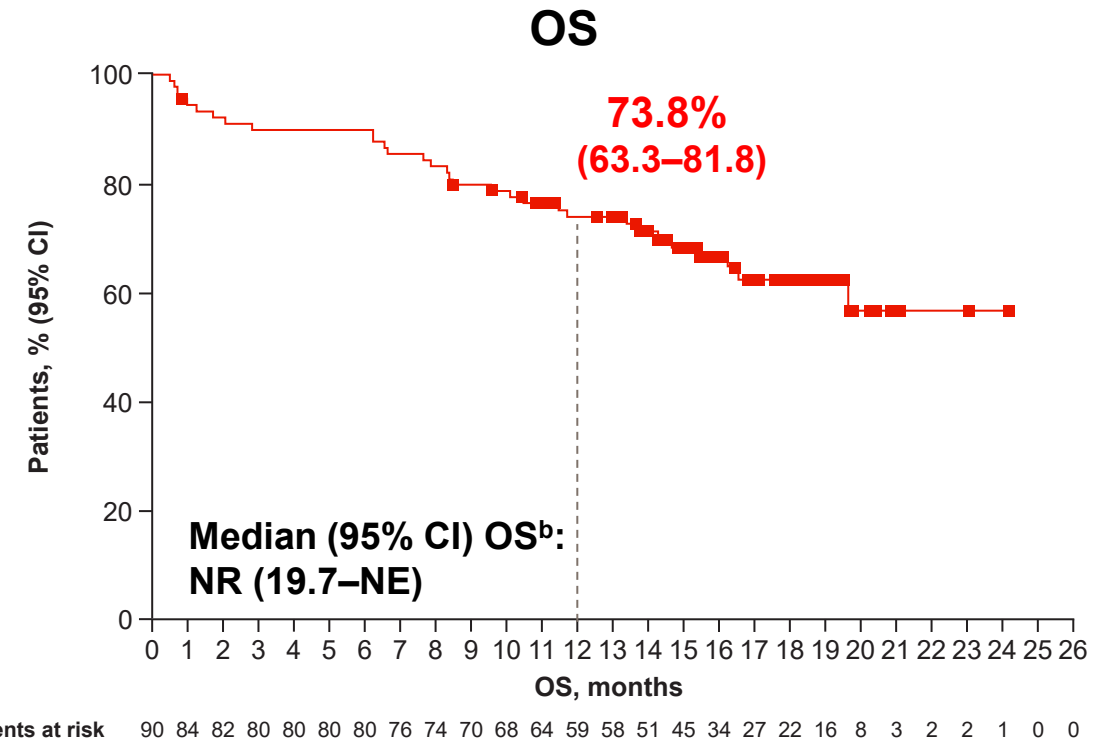
With additional ~4 months of median follow-up, ORR approached 80%; 62% of responders remained in response at 1 year

Data cut-off date: July 18, 2025. [a]ORR was assessed by independent review committee per IMWG criteria. [b]Due to rounding, individual response rates may not sum to the ORR. [c]At time of data cut-off, 43 (60.6%) patients were censored. NE, not estimable; NR, not reached; sCR, stringent complete response.

Presented by S Usmani at the 67th American Society of Hematology (ASH) Annual Meeting; December 6–9, 2025; Orlando, FL, USA

RedirecTT-1 Phase 2 EMD (Tal + Tec): PFS and OS at 16.8 Months Median Follow-up





With over 1 year of median follow-up, median PFS was 15 months and median OS was not reached

Data cut-off date: July 18, 2025. [a]At time of data cut-off, 45 (50.0%) patients were censored for PFS. [b]At time of data cut-off, 59 (65.6%) patients were censored for OS.

Presented by S Usmani at the 67th American Society of Hematology (ASH) Annual Meeting; December 6–9, 2025; Orlando, FL, USA

Etentamig Plus Pomalidomide-Dexamethasone Combination Therapy in Relapsed or Refractory Multiple Myeloma: A Phase 1b Dose-Escalation and Safety Expansion Study

Peter Voorhees[1], Anita D'Souza[2], Hang Quach[3], Sabine Gaerditz[4], Estrella Carrillo Cruz[5], Michał Mielnik[6], Tomasz Wrobel[7], Matthew J. Pianko[8], Dickran Kazandjian[9], M Hasib Sidiqi[10], Valerio De Stefano[11], Cesar Rodriguez[12], Shonali Midha[13], Ariel F. Grajales-Cruz[14], Hideki Goto[15], Satoshi Ito[16], Claudio Cerchione[17], Ziyi Jin[18], Shane Lee[18], Akshanth R. Polepally[18], Sneha Rathi[18], Ross La Motte-Mohs[18], Kristin D'Amico[18], Thomas Doerr[18], Chetasi Talati[18], Leanne Lash Fleming[18], Linda Ho[18], Katja Weisel[19], Marek Hus[6], Joaquin Martinez Lopez[20]

[1]Atrium Health Levine Cancer Institute, Wake Forest University School of Medicine, Charlotte, NC, USA; [2]Division of Hematology/Oncology, Department of Medicine, Froedtert & Medical College of Wisconsin Cancer Center, Milwaukee, WI, USA; [3]St Vincent's Hospital Melbourne, University of Melbourne, Melbourne, Vic, Australia; [4]Department of Hematology and Oncology, University Hospital of Regensburg, Regensburg, Germany; [5]Hospital Universitario Virgen del Rocío, Instituto de Biomedicina (IBIS)/CSIC, Universidad de Sevilla, Sevilla, Spain; [6]Department of Hematooncology and Bone Marrow Transplantation, Medical University of Lublin, Lublin, Poland; [7]Department of Hematology, Blood Neoplasms and Bone Marrow Transplantation, Wroclaw Medical University, Poland; [8]Division of Hematology/Oncology, Department of Internal Medicine, Rogel Cancer Center, University of Michigan Medical School, Ann Arbor, MI, USA; [9]Myeloma Division, Sylvester Comprehensive Cancer Center, University of Miami, Miami, FL, USA; [10]Fiona Stanley Hospital, Perth, WA, Australia; [11]Section of Hematology, Department of Radiological and Hematological Sciences, Catholic University, Fondazione Policlinico Universitario A. Gemelli Istituto di Ricovero e Cura a Carattere Scientifico (IRCCS), Rome, Italy; [12]Division of Hematology-Oncology, Department of Internal Medicine, Mount Sinai, New York, NY, USA; [13]Division of Myeloma, Department of Medical Oncology, Dana-Farber Cancer Institute, Boston, MA, USA; [14]Malignant Hematology, Myeloma Section, H. Lee Moffitt Cancer Center and Research Institute, Tampa, FL, USA; [15]Department of Hematology, Hokkaido University Hospital, Sapporo, Japan; [16]Department of Hematology, Yamagata University Hospital, Yamagata, Japan; [17]IRCCS Istituto Romagnolo per lo Studio dei Tumori (IRST) "Dino Amadori", Meldola (FC), Italy; [18]AbbVie Inc., North Chicago, IL, USA; [19]Department of Oncology, Hematology and Bone Marrow Transplantation with Section of Pneumology, University Medical Center Hamburg-Eppendorf, Hamburg, Germany; [20]Hospital Universitario 12 de Octubre, University Complutense, CIBER-ONC CB16/12/00369, CNIO, Madrid, Spain, Spain.

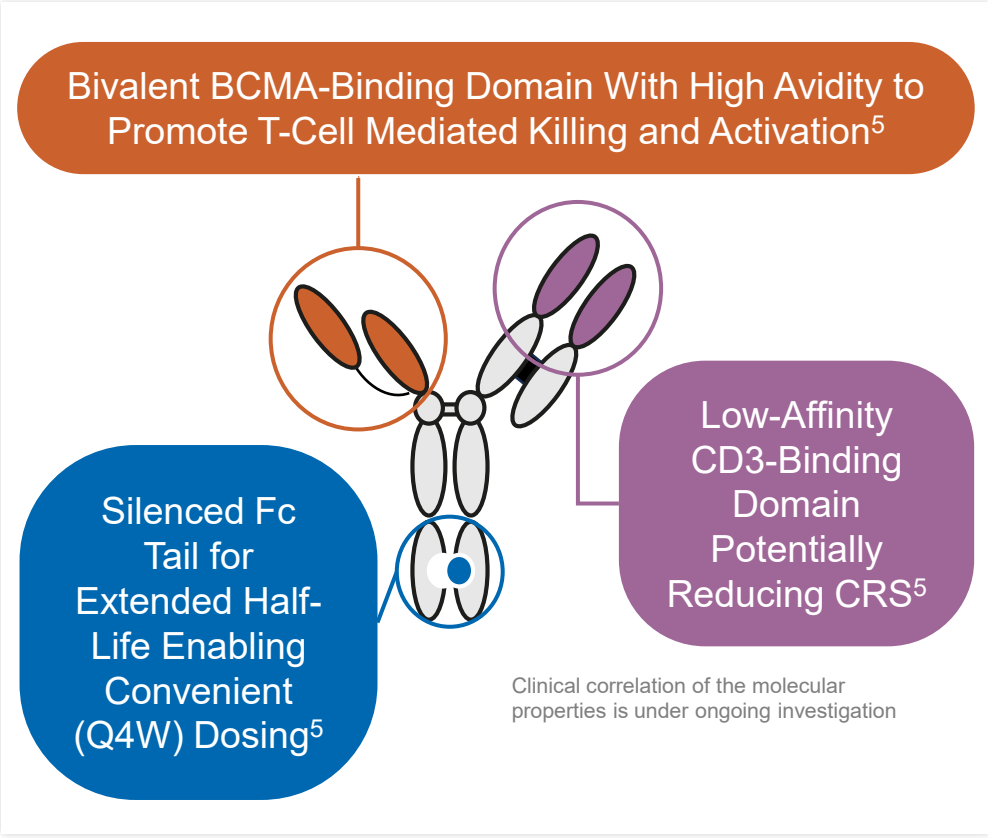
Presented at the 2025 67th American Society of Hematology (ASH) Annual Meeting, December 6–9, 2025; Orlando, FL, United States of America [DV-017508]

Etentamig is a next-generation differentiated BCMA x CD3 bispecific T-cell engager

Long-term results from 2 ongoing Phase 1 studies (NCT03933735/NCT05650632) of Etentamig in heavily pretreated patients with RRMM demonstrate[1,2]:

- 30% overall CRS rate
  - Grade 1: 26%
  - Grade 2: 4%
  - No Grade 3+ events
- Deep and durable responses with 66% ORR
- Convenient treatment schedule, including Q4W dosing

Preclinical data demonstrate enhanced Etentamig activity when used in combination with antimyeloma regimens, including IMiD agents[3,4]

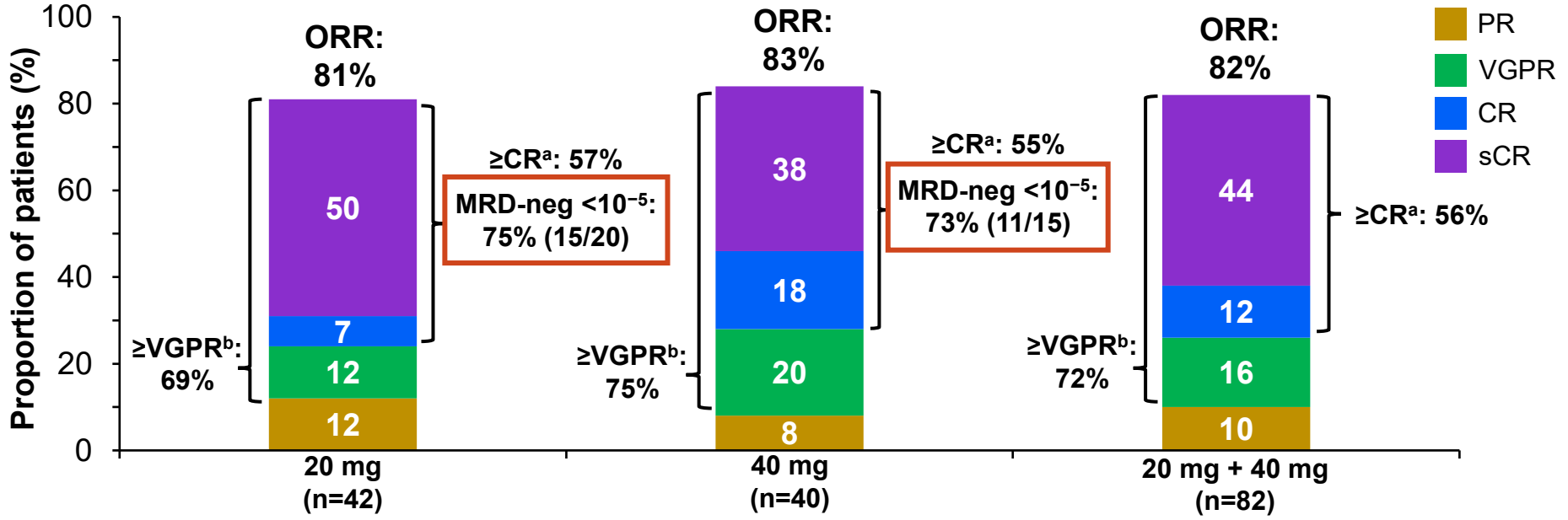


Here we present data on Etentamig in combination with Pom + dex from Arm A (safety and efficacy) and Arm E (safety) of the Kilimanjaro study (NCT05259839) in patients with RRMM

BCMA, B-cell maturation antigen; CRS, cytokine release syndrome; dex, dexamethasone; IMiD, immunomodulatory drug; ORR, overall response rate; Pom, pomalidomide; Q4W, every 4 weeks; RRMM, relapsed or refractory multiple myeloma.

1. Baljevic M, et al. *J Clin Oncol*. 2024;43(16_suppl):7527. 2. Baljević M, et al. Presented at: EHA2025 Congress; June 13, 2025. Poster number: PF722. 3. Meermeier E, et al. *Cancer Res.* 2020;80(16_Suppl):5630. 4. Cho SF, et al. *Blood Adv.* 2020;4(17):4195 –4207. 5. D'Souza A, et al. *J Clin Oncol*. 2022;40(31):3576–3586.

Arm A: Etentamig combined with Pom + dex led to deep responses in heavily pretreated RRMM patient population



Months (range)	Arm A: Etentamig + Pom + dex		
	20 mg (n=44)	40 mg (n=41)	20 mg + 40 mg (N=85)
Median follow up	27 (1–33)	19 (1–26)	23 (1–33)
Median time to first response[c]	1 (1–19)	1 (1–9)	1 (1–19)
Median time to CR	7.0 (3, 21)	6 (3, 16)	7 (3, 21)

Responses in the 40 mg cohort may deepen further with continued follow-up

[a]≥CR: sCR+CR. [b]≥VPGR: VGPR+CR+sCR. [c]Time to response is the time from the date of first dose to the date of first documented PR or better determined by 2016 IMWG criteria. CR, complete response; dex, dexamethasone; IMWG, International Myeloma Working Group; MRD, minimal residual disease; ORR, overall response rate; Pom, pomalidomide; PR, partial response; RRMM, relapsed or refractory multiple myeloma; sCR, stringent complete response; VGPR, very good partial response.

Data cutoff: September 3, 2025

Brief Takeaways On Late Relapse

1. *in vivo* CAR T holds promise for effective CAR T therapy more easily and safely delivered in MM

2. Anitocel and AZD0120 are novel CAR T products with high efficacy and lower risk of neurological toxicities

3. The combination of teclistamab and talquetamab is very potent in EMD

4. Etentamig is a novel bispecific antibody that may be delivered more easily in the community

The Evolution of Myeloma Therapy – MORE to come!

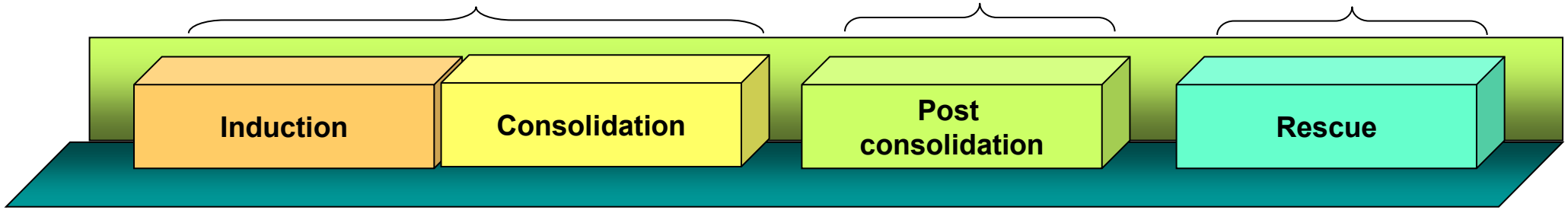
Now

VTD
VRD
KRD
D-VMP
DRD
D-VRD
D-KRD
Isa-KRD

SCT +/- More induction

Lenalidomide
Bortezomib
Ixazomib
Lenalidomide + PI
Carfilzomib
Dara + Lenalidomide

Bortezomib
Lenalidomide
Carfilzomib
Pomalidomide
Selinexor
Idecabtagene autoleucel
Ciltacabtagene autoleucel
Teclistamab
Elranatamab
Belantamab Combinations
Panobinostat
Daratumumab
Ixazomib
Elotuzumab
Isatuximab
Talquetamab
Linvoseltamab



New

Belantamab or Bispecifics?

CAR T or Bispecifics?

Iberdomide, Belanatamab or Bispecifics?

Novel CAR T Cell Therapies
Bispecific/Trispecific Antibodies
Iberdomide and Mezigdomide
Venetoclax/Sonrotoclax for t(11;14)?
Multiple small molecules
++++++++

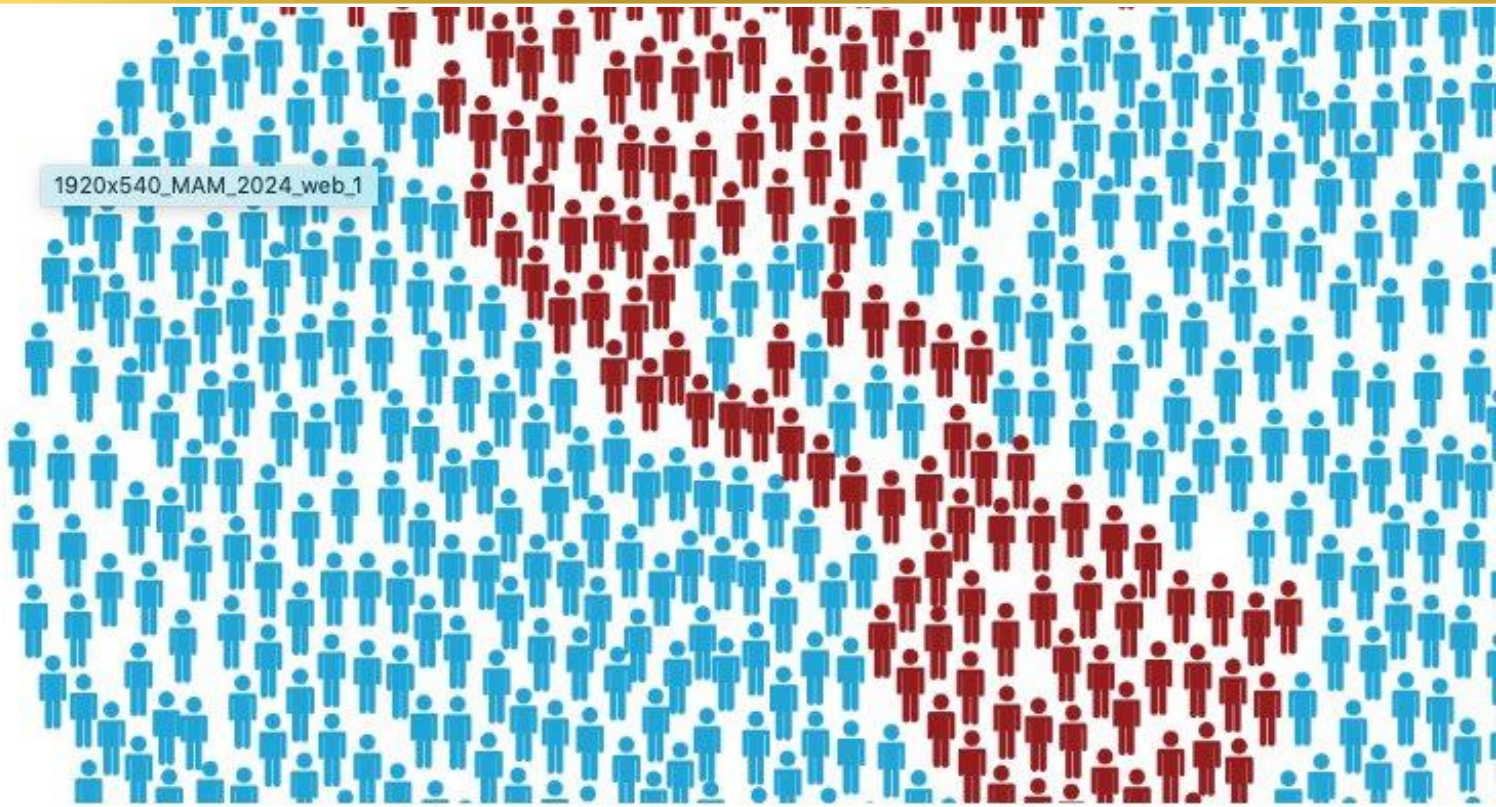
ASCT, autologous stem cell transplant; CAR, chimeric antigen receptor; Cy, cyclophosphamide; d- daratumumab; D/dex, dexamethasone; isa, isatuximab; K, carfilzomib; M, melphalan; PD-L1, programmed death ligand-1; PI, proteasome inhibitor; Rev, lenalidomide; V, bortezomib. Speaker's own opinions.

tgen AN AFFILIATE OF City of Hope

INTERNATIONAL MYELOMA FOUNDATION

MYELOMA ACTION MONTH

#MYELOMAACTIONMONTH

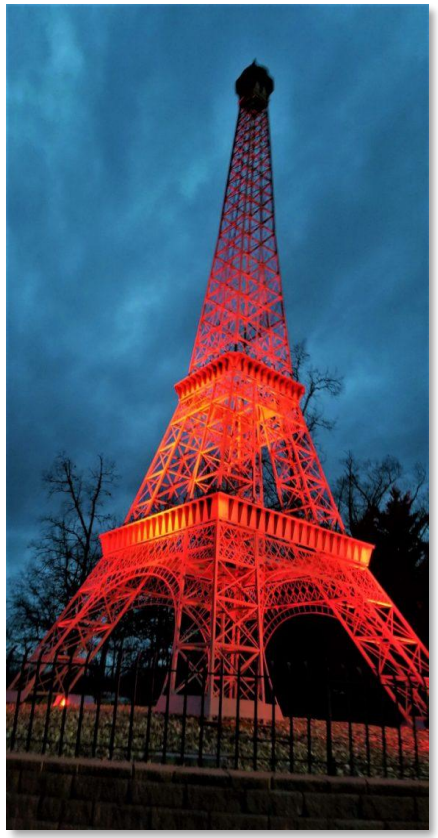
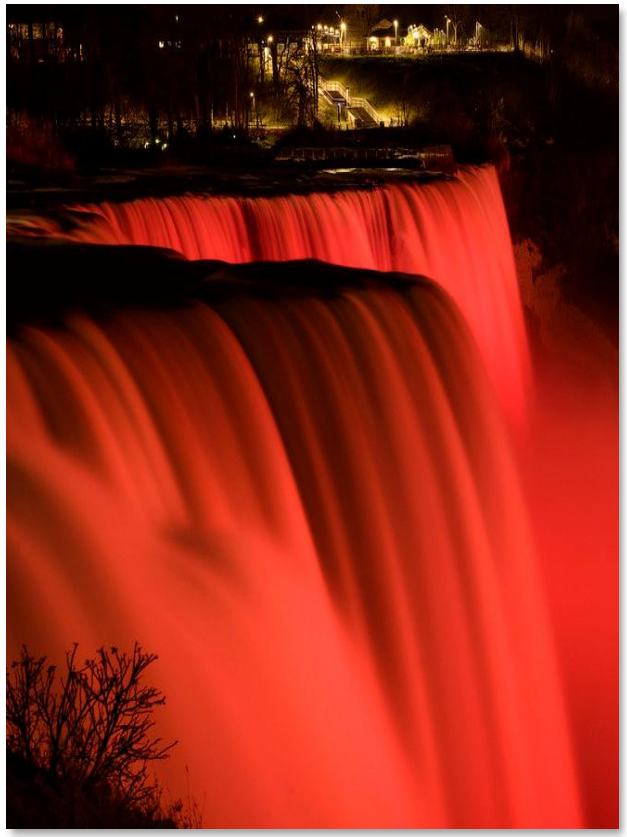


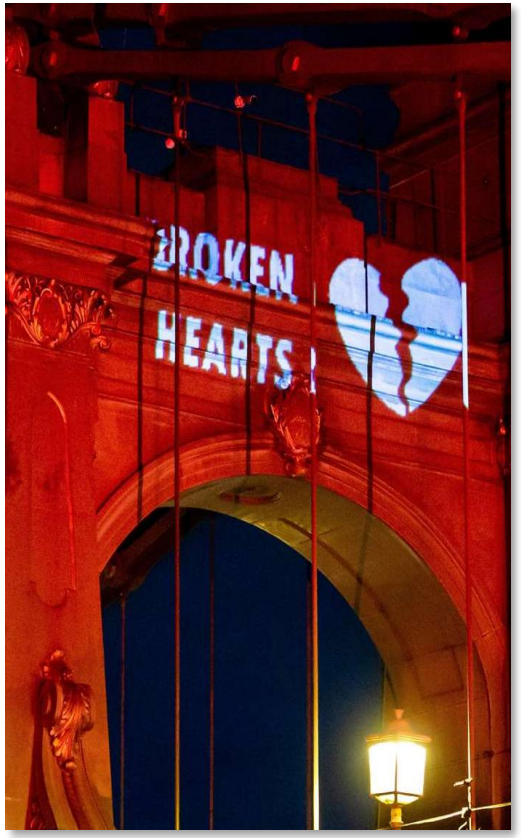
Myeloma Action Month is a **global social awareness** campaign that takes place every March to **raise awareness of multiple myeloma**. We urge the community to **champion Myeloma Action Month** to help make a **positive impact on those suffering** from this blood cancer**.**

Will you take action for the myeloma community?

LIGHT THE WORLD RED! MAM 2026

Our goal is to light as many landmarks globally as we can in the color red to bring awareness to myeloma. Everyone can help with this initiative-let us know if you reach out to landmarks so we can keep track of all of the lightings!



OUR VISION:

A world where every myeloma patient can live life to the fullest, unburdened by the disease.

OUR MISSION:

Improving the quality of life of myeloma patients while working toward prevention and a cure.